

Motivational Interviewing in Intake/Crisis Intervention

by

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## Thesis Review

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### **Abstract**

This Advance Practicum report examines my experiences in further developing my clinical skills, primarily in the area of Motivational Interviewing (MI) techniques, while completing an Advanced Practicum with the Health Sciences North (HSN) Mental Health and Addictions Program (MHAP) as the intake/crisis worker. The intake/crisis program of Manitoulin Island is designed to address the mental health and addiction crisis needs of clients over sixteen years of age who present in psychological distress at either of the emergency departments of the Manitoulin Health Centre (MHC).

My goals within this practicum were to enhance my social work practice skills by facilitating motivational interviewing techniques during intake and crisis interventions, working as part of multidisciplinary team, attending clinical supervision, and diligently critiquing my social work practice with reflective MI log journals and a supervision journal. Throughout this report, I reflect on the critical analysis of the practicum as I focus on two distinct observations and insights within my MI experiences: 1) How can MI enhance treatment compliance? and 2) What challenges might MI methods of interviewing present? Throughout the process of completing this practicum and report, I reflected on the effective use of MI with the different populations that presented, increased my MI skill set, and developed increased self-awareness through reflective social work practise.

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### Introduction

The World Health Organization (WHO) 2018 report, *“Preventing suicide: a global imperative”*, is aimed at addressing the need for increased public awareness on the importance of suicide and suicide attempts. It suggested that countries strengthen their suicide prevention strategies as a part of a multi-sectoral public health approach as suicide is now recognized as a public health priority. On a global scale, “close to 800 000 people die due to suicide every year, which is one person every 40 seconds. There are indications that for each adult who died by suicide there may be more than 20 others attempting suicide” (WHO, 2018, p. 1). WHO (2018) has identified that the link between suicide and mental disorders (depression, alcohol use disorders) has been strongly established in high-income countries but reported that many suicides still occurred impulsively in moments of crisis (financial, relationship breakup, illness). In 2016, in Canada “suicide accounted for 19% of deaths among young aged 10 to 14, 29% among youth aged 15 to 19, and 23% among young adults aged 20-24 (Statistics Canada, 2018a). It is evident that there needs to be more effective response practices by medical and/or mental health practitioners for clients who are accessing services to help address their unmanageable emotional distress, whether for immediate crisis intervention or intake into mental health and/or addiction services.

The rates of suicide and suicide attempts in Canada are alarming. Given the devastation of suicide as a preventable cause of death, it is worth considering how mental health practitioners may be able to improve mental health outcome interventions. “Motivational Interviewing, as a robust evidence-based intervention to increase motivation and commitment to change, is informed by the trans-theoretical model of change and can be adapted for use in brief interventions with people at high risk of attempting suicide” (Hoy, Natarajan, & Petra, 2014, p. 565). The literature reviewed for the purposes of this paper concluded that MI offers an effective

intervention that can increase voluntary treatment uptake for clients who have mental health and/or addiction issues (Bagoien et al., 2013; Colby et al., 2012; Kisley et al., 2017).

I have worked on Manitoulin Island as a rehabilitation practitioner and justice court outreach worker with the Canadian Mental Health Association Sudbury-Manitoulin (CMHA-SM) for over fifteen years, providing support to adults with mental health and/or addiction issues. I shared office space with Health Sciences North (HSN) rural site employees, at the Manitoulin Health Centre (MHC), Little Current. I decided to accept the intake/crisis contract work position with Health Sciences North in order to fulfill the practicum requirements for the Laurentian University Master of Social Work program (please see Appendix A). I was also provided an opportunity to learn MI within this new work experience. In my 450 hour Advanced Practicum, I implemented MI practices with clients who presented for mental health services on Manitoulin Island, whether during crisis services or the intake process, which increased my clinical competencies in the areas of MI. I answered two key questions below as part of this practicum.

### **Key Questions**

- 1) How can MI be used to enhance treatment compliance with people who present at intake/crisis services at the local health centre on Manitoulin Island?
- 2) What challenges might MI methods of interviewing present for individuals accessing intake/crisis services on Manitoulin Island during this practicum?

The aim of this practicum was to achieve my learning objective of increasing my MI skills as I conducted interventions with clients accessing Health Sciences North intake/crisis program support services.

In chapter one, a literature review of MI will be discussed where I examined the eight stages of acquisition needed for a practitioner of MI, MI's effectiveness and limitations, MI's relationship with the trans-theoretical model of change, MI with crisis intervention through the

lens of trauma informed care, and trauma informed care as it relates to the Indigenous population of Manitoulin Island. Throughout this practicum, I relied on my field supervisor to guide my social work practice as I moved social work theory into practice. Therefore, I will also present a literature review of clinical supervision.

In chapter two, structural social work is described and applied to the findings of the two key questions. The practice findings are further compared to the model of the Personal Cultural and Structural levels of oppression (PCS) (Mullaly, 2007) with practicum examples. In Chapter 3, the practicum process and key structure is outlined. In Chapter 4, I described my social work practice within this practicum and its link to reflective social work practice. This practicum is summarized in the conclusion with future implications for social work practice.

## **Chapter 1 - Literature Review**

Motivational interviewing is a conversational style of interviewing based on Rogerian principles of person-centred care (Miller & Rollnick, 2002). It addresses the ambivalence that clients experience when they need to make change through the use of person-centred, goal oriented, and collaborative skills. It is a modality that lends itself well to use in initial or brief contact situations where a social worker is providing support to a client in crisis (Miller & Rollnick, 2002; Hoy et al., 2016).

It is important when considering the introduction of a new skill to the repertoire of a clinician that a number of criteria be satisfied. What is the skill? How is it used? Is it evidence-based? Has it been used in the context that I want to use it? To answer these questions, a literature review is necessary. In the case of motivational interviewing, it was very easy to answer all of the questions asked. In the 35 years since its inception, MI has become a robust, evidence-based practice involving over 1000 publications, 200 randomized clinical trials, dozens of books and videotapes, 10 multi-site clinical trials, and several coding systems for quality assurance (Miller & Rollnick, 2010a).

Since the goal of this practicum was to follow the use of motivational interviewing in a crisis intervention in a mental health and addiction setting, it was important to research this combination. The Laurentian University library was accessed using the databases EbscoHost, Medline, Pubmed, Psychinfo, Social Work Abstracts, and Google Scholar. I used the search strategy “motivational interviewing” and “crisis intervention” or “brief intervention”, selecting peer-reviewed articles only. The search strategy produced few results, which resulted in broadening the search strategy from “crisis intervention” to “mental health” or “trauma” or “addictions”, depending on the databases. The library at HSN was accessed online using the search strategy “motivational interviewing” and “crisis intervention” or “brief service” under the databases Psychology and Behavioural Collections. The MI website research collection was

searched ([www.motivationalinterview.org](http://www.motivationalinterview.org)) with little success as their literature had financial costs or membership requirements attached. Further, this review included books, workshop materials, and an MI training DVD that were used to assist in learning the skills of motivational interviewing. Due to the sheer volume of literature on MI, more recent studies were included. This literature review has been divided into three main sections: Motivational Interviewing, Trauma informed Care, and Social Work Supervision.

### **Motivational Interviewing**

Motivational interviewing was first described in 1983. Its creators, William Miller and Stephen Rollnick (2002), first defined MI as “a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (p. 25). In 2010, Miller & Rollnick (2010b) introduced a new technical therapeutic definition of MI based upon this explosion of knowledge:

MI is a collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a target behaviour change by eliciting and exploring an individual’s own argument for change. (p. 5)

Although motivational interviewing is an easy concept, it is not simple to deliver (Hohman, 2012). It is clear that to competently deliver services at times of crisis using motivational interviewing, the process must be thoroughly understood.

### **Motivational Interviewing Defined in Eight Steps**

Miller and Rollnick (2010a) divided Motivational Interviewing into the Eight Stages: MI spirit, client-centred counseling skills, identification of change talk, elicitation and reinforcement of change talk, rolling with resistance, development of a change plan, consolidation of client commitment, and integration of MI with other treatment methods. It is through the mastery of

each individual skill that MI practitioners assist clients in enhancing their personal motivation for change.

**MI spirit.** The MI spirit or ‘way of being’ was based on three key elements: collaboration, evocation, and autonomy. Collaboration is related to a partnership between the practitioner and the individual. It is grounded in the point of view, values, and past experience of the individual, and used to build rapport and facilitate trust in the therapeutic relationship. A practitioner will evoke or draw out behaviour as an approach that may bring forth the individual’s own reasons and determination to change. Autonomy is emphasized in MI as there is no right way to change, and the true power to change rests with the individual.

**Client-centred counselling skills.** The acronym of OARS in MI is used as a definition for the skilled use of certain techniques that bring to life the MI spirit through the use of micro skills: open ended questions, affirmations, reflections, and summaries.

**Identification of change talk.** Practitioners learn to listen with intention to their clients for any examples of change talk. Change talk is client statements that indicate a readiness for change as stated in the acronym of DARN (desire, ability, reason, or need) or the acronym of CAT (commitment, activation, or steps taken).

**Elicitation and reinforcement of change talk.** Change talk is the most important thing that a practitioner can evoke in an individual. The mobilization talk by the individual are signs that change, if not imminent, may be in the near the future. The practitioner of MI will respond to change talk in a specialized manner with the use of the skills of elaboration, affirmation, reflection, and summary.

**Rolling with Resistance.** Rolling with resistance is a term used by Miller and Rollnick (2010b) to describe the skillful way that practitioners must avoid being drawn into confronting the resistance of clients to change. It must be the client that makes the case for change.

**Development of the change plan.** The change plan will be developed between the client and practitioner, in consultation, as the client readies to take steps towards the changed behaviour.

**Consolidation of client commitment.** The final task in the development of the change plan is described as securing the clients commitment to the plan. At this stage, the plan is reviewed with the practitioner available. It may be a simple validation with a closed question presented, or require more time spent with the client to address any newly arisen hesitation or ambivalence.

**Integration of other treatment modalities.** MI research has highlighted many successful partnerships with other treatment modalities that are specific to various needs of different populations. A few examples of these types of treatment modalities are pre-treatment intervention, pre-screening for alcohol treatment, cognitive-behaviour therapy (CBT), or solution-focused therapy (SFT) (Hohman, 2012).

Rosengren (2009) suggested that practitioners use four main MI principles to guide their work: resisting the righting reflex, understanding the client's motivation, listening to the perspective of the client, and empowering the client. The righting reflex is the desire within the practitioner to solve the problem for the individual. This righting reflex must be avoided, as the practitioner's goal is to minimize resistance by not actively fighting against the individual's resistance to change and causing propagation in the attempt to fix it. This would correspond to Miller and Rollnick's (2010b) rolling with resistance. MI is not about the creation of the motivation for people to change; it is more the practitioner's ability to direct the client toward the discrepancies that already exist between their desires and how their current behavior is impeding the attainment of the desired goal. Within an MI session, the practitioner's goal would be to create an environment of curiosity that would enable the client to easily speak of how and why

the change should happen. The fourth principle of empowerment is the reminder to all that the client must be engaged in the change process and that the practitioner can facilitate this through empowerment. Miller and Rollnick (2002) refer to this as the creation of the 'can do attitude'. In conclusion, the overarching fundamental processes of MI are: (a) engaging as a foundation; (b) guiding the individual toward a strategic focus on their topic of choice; (c) evoking the transition to MI; and (d) planning the bridge to change. MI is not a plan but the process of the development of a client's own motivation and commitment towards creating a plan of their own making (Miller & Rollnick, 2010a).

### **Motivational Interviewing Effectiveness**

It has been over 30 years since MI's inception. Rubak, Sandbaek, Lauritzen, and Christensen (2005) reported that MI has been heavily evaluated in relation to alcohol abuse, drug addiction, adherence to treatment and follow-up, increasing physically active lifestyles, discontinuance of smoking, weight loss promotion, and in the management of chronic diseases such as asthma and diabetes. The meta-analysis of Rubak et al. (2005) reported that 75% of the MI studies they examined obtained a positive effect regardless of whether the problems were psychological or physiological. Throughout these studies, there were no negative effects of MI as a strategy.

MI outperforms traditional advice giving for the treatment of a broad range of behaviors. MI, when compared to advice giving in a randomized clinical trial on adolescent smoking cessation program at baseline and one month, demonstrated a decrease of 4.5% of number of cigarettes smoked per day vs. a decrease of 1.4% in a group only receiving advice (Colby et al., 2012). In a randomized control study, MI was compared with feedback to patients in an emergency department for reducing alcohol use and problems among young adults. Research by



Monti et al. (2007) illustrated that MI decreased use and behaviours at twice the rate when compared to the feedback intervention.

MI has been shown to be effective even in brief patient encounters of only fifteen minutes and, with more than one encounter, an increased likelihood of effect was demonstrated (Rubak et al., 2005). Research by Berman, Forsberg, Durbeej, Kallmen, and Hermansson (2010) suggested that one single session of MI can function as a catalyst to belief in self-change, preparation to change, or decision to change. Research by Bagoien et al. (2013) demonstrated reduced substance use frequency at a two-year follow-up with two sessions of MI delivered to patients.

MI has been combined with other modalities of treatment with success. Research by Heilemann, Pieters, Kehoe, and Yang (2011) combined schema therapy (ST) with MI techniques and showed reduced depression and increased resilience among second generation Latinas of low income in the US with effects during treatment and at one-year follow-up. MI has been used with aftercare planning for people with mental illness, offering better care upon discharge from the hospital, with improvements in the participants' experience of a discharge plan and increased patient involvement and value by participants (Kisley et al., 2017). Research by Benzo (2013) joined MI and mindfulness as an intervention to promote self-management in chronic obstructive pulmonary disease (COPD) patients, relying on the spirit of MI to deliver coaching compassion, acceptance evocation, and collaboration guided sessions. These promising results reflect that "interventions by touching the core of human values and promoting a kind of listening (not only from the mind but also from the heart) can create the necessary condition to ignite motivation and a behavioural change that can be very transformative" (Benzo, 2013, p. 6).

MI has been modified to reach other treatment populations and as an enhancement for other therapies. Research by Martino, Carroll, Kosta, Perkins, and Rousaville (2002) illustrated

that MI can be modified for success for substance-abusing patients with psychotic disorders by simplifying open-ended questions, refining reflective listening skills, increasing the emphasis on affirmations, integrating psychiatric issues into personalized feedback, using decisional balance matrices, and accommodating cognitive impairments and disorganized thinking.

Currently, MI is offered with web-based technology in health care settings with little staff intervention. A study of web-based MI illustrated that MI shows promise for increasing physical activity participation in a health care setting (Karnes, Meyer, Berger, & Brondino, 2015). This type of intervention was created to meet the demands of time limited physicians and their patients in that the intervention is brief, and the delivery format requires limited involvement of health care professionals. MI accessed by web-based technology is unknown as to its impact on future cost savings for health care and to the potential of health benefits for its patients.

### **Limitations to Motivational Interviewing**

The concepts of MI and its use have grown and changed over the years from being an effective intervention for those primarily with alcohol addictions to addressing a variety of health care and other behavioural problems. As this expansion of MI has taken place, limitations have been discovered. In relationship to this practicum, unless an individual is medically stable (not intoxicated or under the influence of chemical substance) a crisis intervention or intake cannot take place. Clients who present at MHC in mental health crisis may have exacerbated symptoms of their mental health condition that render them cognitively incapable (delusions, psychosis) to participate in the thought processes for the work of MI, but a crisis or intake assessment can still be done based on the observation of the practitioner. Clients always have the right to refuse a crisis intervention or intake assessment, and this right to refuse is a general rule that is accepted by practitioners, as both these services are voluntary.

Hohman (2012) suggested that MI methods do not utilize the ‘person-in-environment perspective’, as they do not consider the impact of the multiple systems that clients are impacted by in their daily lives. For example, a youth would benefit from the positive interaction of MI to alleviate his crisis situation but is also still challenged by other problems such as living in a high-crime area or being subjected to peer pressure to use substances. The concern raised here is that social workers like to focus on just the individual client, as the survivor of interpersonal violence, within MI, without focusing on the culture of violence perpetuated through media and music. MI can begin the process for the development of plans moving clients forward, but it is also important to give thought to these systemic problems, barriers, and solutions that occur for clients within a context (Hohman, 2012).

Another area of limitation for MI for social work practice is the challenge of the mastery of the skill sets of MI, as research has shown that MI skill acquisition requires ongoing supervision, coaching, and feedback (Rosengren, 2009). Hogue, Dauber, Lichvar, Bobek, and Henderson (2015) created a viable therapist-reporting tool for the combination of MI and cognitive behaviour therapy (CBT) treatment sessions, which are commonly used in evidence-based practice today. CBT is a form of psychotherapy that helps clients to identify their thoughts, beliefs, and attitudes. With that insight, observations are made on how thoughts may impact on feelings and behavior. It was illustrated that, when therapists and trained observation raters reported outcomes, the therapists’ reliability was nonexistent as they overestimated the extent to which they implemented MI/CBT techniques in session (Hogue et al., 2014). This is an example of MI skills that were not fully developed, and, therefore, practitioners were not effective with the use of MI.

MI has been used as an intervention in various organizational structures, as part of a practitioner’s own self-reporting tool within supervisory sessions. A recent study by van den

Berk-Clark, Patterson Silver Wolf, and Ramsey (2015) evaluated MI in a permanent supportive housing agency and found the effectiveness of MI was dependent on having a singular agency mission. In this study, the agency agenda (not the client agenda) was typically prioritized when it came to the utilization of MI. For this reason, MI treatments often seemed overly simplistic to workers and had limited benefit. The workers struggled with how to use MI to motivate clients to change within this environment. This resulted in worker-to-worker conflict. It became clear that when management was not trained in MI and did not invest in a MI champion for front line staff, the effectiveness of MI was greatly diminished.

### **Motivational Interviewing and the Transtheoretical Model of Change**

MI's foundation shares a common heritage with Prochaska and DiClemente's (1992) Transtheoretical Model of Change (TTM). The TTM complements MI with its five-stage model of change readiness: precontemplation, contemplation, preparation, action, and maintenance. According to Prochaska and DiClemente (1992), each stage contains related levels of tasks to be completed before moving on to the next stage. In the precontemplation stage, clients do not show any signs of a desire to change the problem behaviour, may be resistant to change, or feel they do not have the ability to change. In the contemplation stage, individuals begin to weigh the pros and cons of change, begin to seek information, and show distress and ambivalence about changing. The preparation stage of change includes the creation of a concrete plan of action. The action stage is a time of effective implementation of the change behaviour into daily living. The last stage, maintenance, describes a strengthening of comfort level with the new change in behaviour. The stages of change, although presented here as sequential, may include periods of relapse behaviours in the change process for the individual.

Moving through the stages of change requires differing strategies for each stage, but it is motivation for change that will provide the impetus for moving from stage to stage. According to

DiClemente, one of the founders of the transtheoretical model, and Velasquez the “Motivational Interviewing philosophy, approach and methods are uniquely suited to addressing the tasks and emotional reactions of individuals moving through the first two stages of change” (DiClemente & Velasquez, 2002, p. 203). For clients in the precontemplation stage, clinicians used MI to help clients understand their own situations, consider the pros and cons of changing, and make the decision to embark upon a change plan that would propel them to the preparation phase of the stages of change (DiClemente & Velasquez, 2002).

### **Motivational Interviewing and Intake/Crisis Interventions**

MI, a robust evidence-based intervention to increase motivation and commitment to change, is informed by the transtheoretical model of change, and can be adapted for use in brief interventions with people at high risk of attempting suicide (Hoy et al., 2016). It is understood that individuals accessing crisis and intake services usually present at the precontemplation or contemplation stages of change. Individuals accessing crisis assessment services are screened for risk to self or others. If the individual is at high risk, a referral for psychiatric evaluation will be recommended to the emergency doctor. If the emergency doctor is in agreement, he/she can write what is commonly referred to as a ‘Form One’, an application by a physician for psychiatric assessment under the Ontario Mental Health Act (1990, c.M.7). This form is based upon the Ontario law that regulates the administration of mental health care, allowing an individual to be held involuntarily in a psychiatric facility for up to seventy-two hours in order to undergo a psychiatric assessment. This assessment is to determine whether the individual requires the care and supervision that a psychiatric hospital can provide. A psychiatrist will make the decision to release the individual or admit them to hospital in either an informal/involuntary or voluntary capacity (Ministry of Health and Long-Term Care, 2016). If the individual is at low

or moderate risk for suicide then a concrete safety plan will be developed, which aligns with the preparation stage in the model of change.

According to Miller and Rollnick (2002), it is most obvious to offer MI as a first consultation, a prelude to other services. This reflection supports the use of MI at the point of crisis intervention and intake into mental health and addiction services. According to Britton, Patrick, Wenzel, and Williams (2011), MI and self-determination theory with cognitive behaviour theory are being used in the prevention of suicide. MI is ideal in this situation as it elicits and reflects a client's reasons for dying, which frees them to explain their reasons for living. To build motivation to live, practitioners help clients to explore reasons to live in greater depth. After exploring reasons for living and dying, clients often can find reasons to live but realize that they need to make some changes to ensure their lives will be worth living. When clients are ready to talk about changes, the practitioner would explore potential changes including their participation in treatment that addresses their reasons for wanting to die.

MI techniques, such as MI scaling, can be used with crisis intervention when an individual is at high risk for attempting suicide. Hoy et al. (2016) created a number of questions to ask in crisis intervention that use MI scaling: (a) Tell me, on a scale from one to four where one is low and four is high, how likely are you to act on your suicide plan? (b) Why not a higher number? (c) Why not a lower number? These questions are designed to bring out the individual's own ideas and point to protective factors (reasons to live). This brief MI intervention could lessen the level of suicidal risk and increase the chance that a client would lower the strength of their decision to complete suicide to a preparation stage from an action stage. In addition to asking the MI scaling questions, it is necessary that the practitioner listen for information regarding intentions to change, for readiness to start making the change, or for any barriers the individual may perceive to making a change. Some follow up questions or reflections could be

used to elicit more discussion about the importance of change for the person, reasons to engage in healthy behaviour changes (or to not engage in self-destructive risk behaviors), and/or the increases in motivation for making healthier choices.

### **Trauma informed Care**

Traumatic experiences are very commonplace in Canada as 76% of adults reported some form of trauma exposure and 9.2% meet the criteria for post-traumatic stress disorder (Van Ameringen, Mancini, Patterson, & Boyle, 2008). Poole, Urquhart, Jasiura, Smylie, & Schmidt, (2013) suggested that trauma exposure may lead to debilitating responses such as anxiety, horror, shock, shame, emotional numbness, withdrawal, intrusive thoughts, helplessness, and powerlessness. Trauma reactions ranged from individual to individual, from small disruptions to debilitating suffering. Nightmares, memory flashbacks, despair, irritability, and jitteriness are common reactions to trauma. These responses can interfere with an individual's sense of safety, self, and self-efficacy, as well as their ability to regulate emotions and have healthy relationships (Poole et al., 2013). People may also develop physiological adaptations in response to trauma, such as perceiving ongoing threats, which lead to underlying states of dysregulation and difficulty controlling or regulating emotional reactions. People can be in a state of hyperarousal and hypervigilance (where an individual seems to overreact to every situation), or listlessness and dissociation (in which an individual appears numb and disconnected in overwhelming or dangerous situations) (Poole et al., 2013). This dysregulation of the brain and body systems perpetuates mental, physical, spiritual, and emotional distress. Prolonged distress at these levels can begin to generate disease in the body such as gynecological difficulties or gastrointestinal problems. Heightened states in the body can, over time, impact the immune system leading to the development of chronic immune diseases (Poole et al., 2013).

Dube et al. (1998), in an adverse events study, provided evidence that stressful childhood events influence mental health, physical health, and disease in adulthood, with increased levels of trauma leading to deprived outcomes throughout an individual's lifetime. These adverse life effects can include frequent physical, emotional, and/or sexual abuse, maternal depression or family mental illness, and parental incarceration. Hager and Runtz (2012) identified that trauma survivors are excessive consumers of primary care visits for illness and emergency care services.

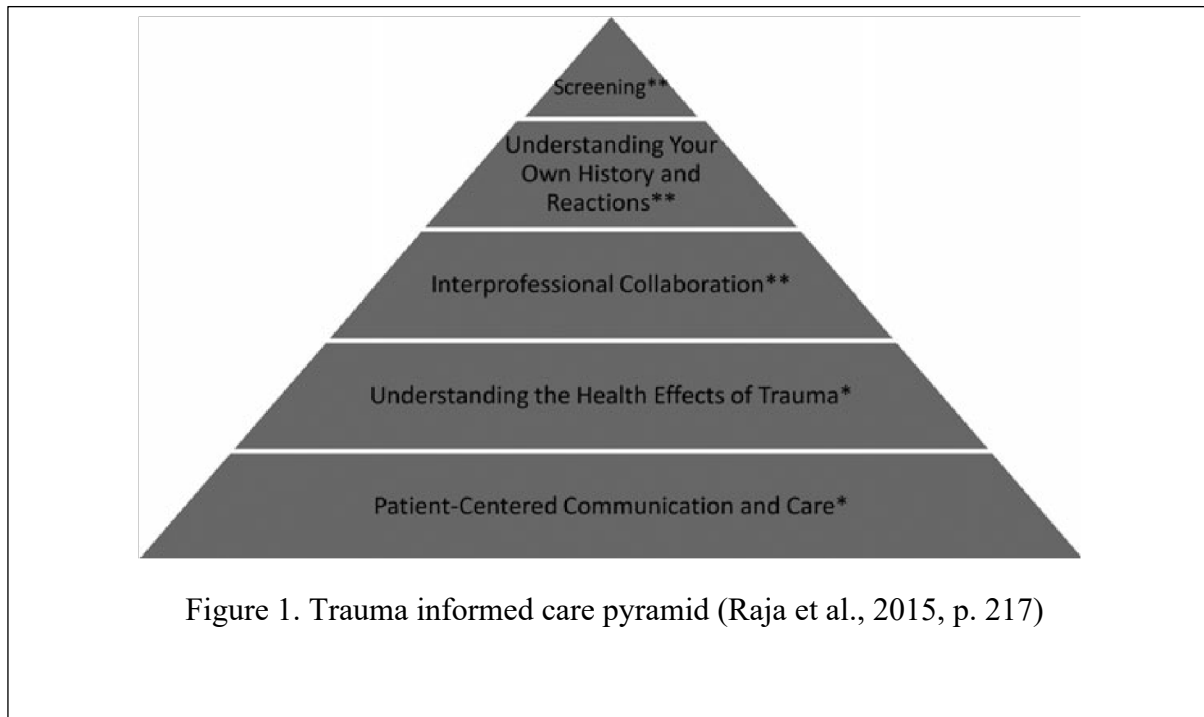
Due to the number of people affected by traumatic events and due to the severity of the ongoing reactions to trauma which some people experience, it is necessary that health care services consider the effects of trauma on their clients. Poole et al. (2013) depicted trauma-informed care as a service delivered by providers that understand the impact of trauma and consider it in all aspects of its service delivery. They suggested that trauma informed care service delivery sets out to create an environment where service users do not experience further traumatization or re-traumatization (by asking clients to recall events that reflect earlier experiences of powerlessness and loss of control) and where individuals can make decisions about their treatment needs at a pace that feels safe to them.

Raja, Hasnain, Hoersch, Gove-Yin, and Rajagoplan (2015) developed a pyramid that describes trauma informed care in medical settings as two distinct categories: universal trauma precautions and trauma-specific care. Universal trauma precautions will be discussed here, but trauma-specific care or trauma treatment will not as it is not a part of the intake or crisis intervention process.

Universal trauma precautions are of extreme importance in emergency departments during a crisis assessment with a client. Individuals who present at the emergency department may or may not have already identified that they feel 'unsafe' or that they are 'unsafe towards others' in the community. They, therefore, will need to be assessed for their level of risk. It is the



role of the crisis worker, in consultation with the acting physician on duty, to rate the level of risk with which the client is presenting, and to create the appropriate safety plan to mitigate the level of risk. The pyramid described in Figure 1 encompasses this concept of what universal trauma informed means to the individual.



Raja et al. (2015) described the bottom of the pyramid as representing exceptional client-centred care and information exchange. At this level, a reduction of client anxiety may be obtained by verbal orientation to procedures, hand signals for anxiety, asking how to increase client comfort levels, and increasing rapport. The second step includes the practitioner understanding the health effects of trauma (maladaptive coping such as smoking, substance abuse, overeating, and high-risk sexual behaviour) and engaging in non-judgemental approaches. The third step involves interprofessional collaboration that includes offering lists of referral resources over all disciplines, providing trauma information available in sitting areas, and engaging in interprofessional collaboration to ensure continuity of care. The fourth step includes practitioner reflection and self-care. Practitioners must know their own trauma histories and

their reactions to trauma as their personal trauma can impact their clients. The top of the pyramid addresses the need to screen clients for trauma. It is important, at this level, that agency decisions be in place about the need to screen for trauma, how to use a framing statement prior to trauma screen, providing staff education on how to discuss a positive trauma screen with a client, and follow up.

Universal trauma care, as illustrated by Raja et al. (2015) in their pyramid concept, aligns with motivational interviewing. The pyramid base, patient-centred communication and care, reflects the same strong belief that is carried out in the eight stages of MI, which, in MI, is referred to as client-centred counseling skills (Miller & Rollnick, 2010a). Step two of the pyramid addresses the need for the MI practitioner to be knowledgeable in how trauma presents in individuals and to align themselves in a non-judgemental stance when discussing with the client some of their maladaptive coping practices. Motivational interviewing is grounded in the point of view, values, and experiences of the client. The non-judgemental way that the practitioner explores with the client the need for change builds rapport and facilitates trust in the helping relationship (Miller & Rollnick, 2010a). Steps three to five reflect how the working environment is established and how practitioners are to work within a trauma-focused environment. Overall, the trauma informed care pyramid fits with the spirit of MI that includes collaboration, evocation, and autonomy (Miller & Rollnick, 2010a).

Poole et al. (2013) have identified four common principles of trauma informed approaches throughout the literature. The first principle is trauma awareness among practitioners in learning the impacts of trauma, how it can change one's development, how people cope and survive trauma, and the relationship between trauma and substance use. The second principle emphasizes the integration of safety and trustworthiness, using physical, emotional, and cultural safety practices, because trauma survivors may have experienced the abuse of power in

important relationships, and may currently be in unsafe relationships or living places. The intake/crisis intervention processes include providing safety for and instilling trust in clients. Safety and trustworthiness can be built in by including clear welcoming intake procedures, changing the physical space to be less threatening, providing clear information about programming, and ensuring informed consent creates crisis plans that demonstrate predictable expectations. Safety is also emphasized for the staff in a trauma informed approach. Staff safety can include education, clinical supervision, and policies that support staff self-care. The third principle is to create opportunity for choice, collaboration, and connection in a safe environment that fosters a sense of efficacy, self-determination, dignity, and personal control when receiving care. Practitioners communicate openly to equalize power imbalances in relationships, allow the expression of feelings without fear of judgement, and provide treatment choices. The fourth principle includes strength-based modalities and skill building. Practitioners assist individuals to develop resilience and coping skills as practitioners emphasize recognizing triggers, calming, centering, and staying present.

Poole et al. (2013), in their *Trauma Informed Practice Guide*, illustrated that it is important that individuals suffering from traumatic events receive collaborative care, respect for their autonomy, and are encouraged to play an active role in their treatment. Poole et al. (2013) stated that MI is the primary approach that creates trauma informed care practices, with its specific change talk skills and ability to elicit change talk in the interactions between the individual suffering from the distress of trauma and practitioner. They recommended that practitioners use the skills of OARS (open-ended questions, affirmation, reflection, and summary) as primary practitioner skill sets and noted that the MI strategy for sharing information, elicit-provide-elicite, integrates well with a trauma informed approach. The practitioner begins by drawing out what the client may already know about a specific topic,

builds from this offering with permission, provides information tailored to the client's topic, and ends by again eliciting the client's voice as to their understanding of the information shared (Poole et al., 2013). This drawing out of information is especially important as practitioners providing trauma informed care need to consider that clients' trauma experiences will present uniquely. For example, the Aboriginal culture may have very different historical experiences and current life developmental experiences than the mainstream. As a practitioner, sensitivity to a different cultural experience of trauma will demand that the practitioner avoid making assumptions, respect readiness to receive information, and clarify what has been heard and how it may or may not fit with their own experience of trauma.

### **Trauma Informed Care and MI with Indigenous Populations**

Where Canada consistently ranks in the top five countries for economic development, if the Indigenous population in Canada was viewed as a sub-group, they would rank 48th out of 174 countries (United Nations, 2006). There may be, therefore, drastic differences in the overall developmental successes between Indigenous and non-Indigenous people living on Manitoulin Island. Since Indigenous people make up approximately 41% of the population of Manitoulin Island (Statistics Canada, 2018b), it is important that the experiences of Indigenous people be understood and considered when they engage in crisis services.

Fast and Collin-Vézina (2010) recommended that trauma models be expanded to consider the diversity of the historical and current day experiences of Indigenous people. Research has identified that the experience of the genocide during the Holocaust is parallel to the enculturation and oppressive practices and policies of the Canadian government towards the Indigenous peoples of Canada (Fast & Collin-Vézina, 2010). The Indigenous population has experienced different types of trauma, based on the direct effects of colonization, such as intergenerational trauma, historical trauma, and race-based trauma than the mainstream population.

Evans-Campbell (2008) suggested that Indigenous people be assessed on three different levels for traumatic experiences and symptoms of trauma: the individual, the family, and the community. The different types of trauma that affect Indigenous populations (intergenerational, historical, and race-based) can each impact an individual. Thus, the complexity of Indigenous trauma needs to be considered on all levels. On an individual basis, an Indigenous person can suffer with the symptoms of trauma in the mental and/or physical domain, through illness such as post-traumatic stress disorder. At the Indigenous family level, trauma symptoms can appear as impaired communication skills and increased parenting stress through poor attachment bonding with their children. The entire community can experience trauma effects from the breakdown and loss of cultural traditions and values, loss of traditional rites of passage, physical illness (obesity), high rates of alcohol consumption, and internalizing racism (Duran & Duran, 1995). When looking at the life experience of Indigenous people, it is important to pay particular attention to the level of community wellness. The United Nations (2006) reported that in Canada, “when using a community-well-being index (CWB), that takes into account education, income, housing and labour force participation, among the ‘bottom 100 Canadian communities’, 92 are First Nations” (p. 127). This community wellness index strongly illustrated the difference that Indigenous people experience, in comparison to their non-Indigenous counterparts, and needs to be considered so that Indigenous people who present to crisis services in traumatic distress can be properly accommodated.

### **Social Work Supervision**

Social workers value both the education and emotional support that supervision provides, given that it has been shown to increase both individual work competency and work satisfaction (Kanno & Koeske, 2010; Karpetis, 2010). Social workers work in vastly different work environments with various types of supervisorial practices, which are left up to the discretion of

the individual employer. This can lead to inappropriate or inconsistent social work supervision practices. As Karvinen-Niinikoski (2016) suggested, supervision can be used as a forum for reflection, allowing social workers to reflect on their own experiences and emotions. With a critical reflection practice, they may begin to understand themselves in the wider context of the workplace, community, and society, and thus look for alternative methods of reaction, action, and agency (Karvinen-Niinikoski, 2016). Ruch (2002) introduced the concept of reflective social work practice as one that involves acknowledging the uniqueness of each situation encountered and the extraordinary complexity of human functioning, whether in relation to individual personalities, family dynamics or inter-professional relations, and perhaps most pertinently, the anxiety invoked in practitioners by the work they do. Sheppard, Newstead, Di Caccavo, and Ryan (2000) defined reflective practice as one that is analytical and critical, penetrating all aspects of the work of a social worker.

## **Conclusion**

MI is an evidence-based robust intervention style that has proven effective in treating addictions, promoting physical health style changes and engagement into services and as an adjunct to other treatment modalities. MI has been modified to reach specific populations including discharges from mental health services and youth populations. Coupled with other treatment modalities MI has been helpful when intervening with clients with suicidal ideation. Based on this literature review, MI, with its diversity and proven intervention validity, was a solid choice to include with intake/crisis interventions with a universal trauma approach. Specific attention was given to the Indigenous population to aid in the support of providing culturally appropriate and sensitive care to this marginalized population. During this practicum, I studied using MI as described in the eight stages by Miller and Rollnick (2010b) in order to integrate it into intake/crisis interventions.

In Chapter 2, treatment compliance and MI challenges from the client perspectives will be identified from the findings as outlined in my journals. Through the lens of structural social work these practicum findings are reported in relationship to the different levels of oppression: personal, cultural and structural.

## Chapter 2 – Structural Social Work

A structural social work stance helps us to understand how oppression occurs and how it is practised in our contemporary society. Mullaly (2007) described the goal of structural social work as two-fold: 1) to alleviate the harmful effects on people by an exploitative and alienating social order; and 2) to alter the conditions and social structures that cause these harmful effects. Mullaly (2007) suggested that in this 21<sup>st</sup> century, oppression exists as a split from the old view of a visible dominant oppressor (evil conscious or deliberate acts of dominance) over a lower social group, as oppression is more concealed within the structure of social constructs. Mullaly (2007) reflected that eliminating the leaders of society or creating new laws would not change structural oppression, as it is systematically reproduced in key economic, political, and cultural institutions and spread by interactions of media, cultural stereotypes, structural features of bureaucratic hierarchies, and global market mechanisms. Mullaly (2007) determined that oppression occurs in the context of our everyday interactions. Many people contribute to the maintenance and reproduction of oppression while carrying out their day-to-day activities, yet they are unaware they are agents of oppression (Mullaly, 2007). Structural oppression is reinforced through “systemic constraints on subordinate groups that take the form of unquestioned norms, behaviours, and symbols and in the underlying assumptions of institutional rules” (Mullaly, 2007, p. 261).

Structural social work encompasses oppression that can be depicted as three levels of oppression:

...the personal or individual level, the cultural level, and the structural or institutional level (Dominelli, 1997; Mullaly, 2002; Thompson, 1997). Each of these three levels or location is interdependent, interactive, and mutually reinforcing with respect to the other levels...each level of oppression influences and reinforces oppression on the other two



levels. Thompson (1997) has named this the multi-dimensional perspective the Personal, Cultural, Structural (PCS) model of analysis. (Mullaly, 2007, p. 261-262)

The personal level is associated with an individual's personal identity that is linked with physical, psychological, social, and cultural variables such as appearance, personality, social status, class, race, or ethnicity. A person's social identity is rarely based on one identifiable characteristic, as people can be members of various distinctly different groups that confer dominant or subordinate status. This is reflected in the concept of intersectionality, which is the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism) combine, overlap, or interacts into multiple identities and experiences of exclusion and subordination, especially in the experience of marginalized groups. Mullaly (2007) defined oppression at the personal level as beliefs, mind-sets, and actions that explain hurtful conclusions about a specific subordinate group which is commonly grounded in cultural stereotypes of a hidden or blatant nature.

Oppression at the cultural level of this model pertains to values, norms, and shared patterns of thought and action, along with an assumed consensus about what is right and 'normal', and when viewed together, endorse the belief in a superior culture. The underlying message presented here is that the dominant culture is the rule, and everyone must conform to it (Mullaly, 2007).

Oppression at the structural level refers to the means by which oppression has been institutionalized in society. This level of oppression is given its formal legitimation as it is the way that social institutions laws, policy, and social processes and practices all work together primarily in favour of the dominant group at the expense of the subordinate groups (Mullaly, 2007). Awareness of social constructs and how they oppress marginalized groups is important in ethical social work practise.

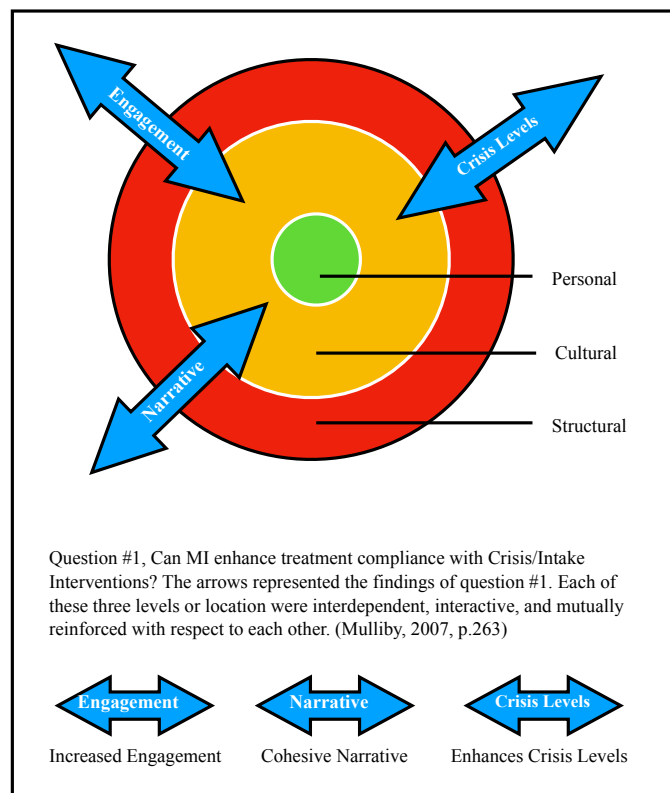
**Context of the Practise Problem #1**

Practise problem #1 examined how MI can enhance treatment compliance. The three main findings can be interpreted by using the multi-dimensional Personal, Cultural, and Structural PCS model of analysis (Mullaly, 2007). During this practicum, I discovered three areas that support MI as an enhancement for treatment compliance for clients who accessed intake/crisis support services on Manitoulin Island.

Treatment compliance is a term used in mental health and addiction services, usually referring to medication adherence, to describe whether a client is engaged in the treatment that has been previously prescribed to them by a medical practitioner. Emmons and Rollnick (2001) found that traditional approaches in health care put practitioners in the “expert” role and place the client in the position of accepting the advice being communicated or resisting it, either directly or indirectly, through lack of adherence to the specific recommendations. If an individual adheres to their treatment plan, then they are considered to be in treatment compliance and are looked on in a favourable manner by medical practitioners. If an individual does not follow their treatment plan they are considered not to be treatment compliant and are viewed as disobedient. The use of this term in itself is oppressive, as it is paternalistic in nature, and requiring compliance to treatment discredits personal choice and the autonomy of the client. Strength-based practices and the philosophy of mental health recovery no longer use this term because it has been viewed as oppressive language (Drake, Deegan, & Rapp, 2010). In hindsight, the use of the term treatment compliance in my question #2 was, in itself, another agent of oppressive language. In comparison, the MI approach positions the client in the role of expert, in that he or she has the freedom to select how to interpret and integrate the information that is received, and whether or not it has any personal importance moving forward in their choice of treatment options (Emmons & Rollnick, 2001).

My first discovery was that MI complimented the levels of crisis as depicted by Flannery & Everly (2000). My second discovery was that MI developed a cohesive narrative as reported by Rosengren (2009). My third discovery was that MI had a strong focus on engagement with the client, which did increase participation in program services as reflected in Carroll et al. (2006). These findings were added to the model below as a reflection of how they can also be included in the dynamic, interdependent, interactive, and mutually reinforcing activity that occurred within each level of oppression of the PCS model. Each discovery will be discussed in the following section.

Figure 2. PCS Model of Oppression with Question #1 Findings



**Complements crisis levels.** I found the work of MI during a crisis intervention to be beneficial in the movement of clients out of the initial crisis response and into the functionality

of the management of their own psychological distress that was the sequential goal of a crisis intervention. Flannery and Everly (2000) defined the five common basic principles that underpin the work of a crisis worker during a crisis intervention as immediate intervention, stabilization, facilitated understanding, focused problem solving, and encouragement of self-reliance. Miller and Rollnick (2002) defined three common MI principles in the underpinnings for a MI practitioner as collaboration, evocation, and autonomy. The principles of MI are parallel to the principles of crisis intervention work as defined by Flannery and Everly (2000).

During this practicum, to intervene immediately and to emotionally stabilize clients was the role of the emergency department nursing staff, as they were the first to interview the clients who presented at either MHC emergency department. They decided if the presentation warranted a risk assessment with the crisis program and if the client required medication to be medically stabilized from their emotional/physical symptoms of distress. The response times of the HSN crisis program are totally dependent on how quickly the emergency department contacts HSN for a referral and which emergency department requested the service, as the Mindemoya emergency department is located a half an hour drive away, and the Little Current emergency department is a two-minute walk down a flight of stairs from the HSN office. For example, the protocol of both of the Manitoulin Health Centre's emergency departments are that the crisis checks in with the charge nurse for an exchange of information prior to meeting with the client. The charge nurse shares the emergency staff's written documentation (demographic, medical, reason for visit, medications, current emotional state) and then the charge nurse will comment on the present state of the individual (i.e. client is now calmer due the sedative medication given). During this practicum, I learned to rely on my MI skills to gather information first hand from the individual during the intervention.

Flannery and Everly (2000) focused on the principle of stabilization and understanding that can be directly related to the MI principle of collaboration. According to Rosengren (2009), collaboration refers to a collective stance in MI, where the practitioner works in partnership with the client toward a solution to their presenting complaint. This collaboration with the client has been based on the acceptance by the practitioner that the client is the expert on themselves, their histories, their circumstances, and their efforts to change. The practitioner respects and demonstrates the belief that the client is the expert and, therefore, tries to understand the client's aspirations and goals, creating a positive environment so that change is a comfortable possibility. I have noticed in this practicum that when clients felt safe and comfortable in my presence, their bodies appear relaxed and the cadence of their voice slowed down. They were more likely to provide more information on how they were feeling and some of their own ideas about how to solve their own issues. In MI, the practitioner avoids prescriptive and proscriptive advice which is commonplace in the scientific/medical models of health care and, therefore, in the structural practices of the emergency department (Emmons & Rollnick, 2001). For example, when clients come to the emergency department to ensure a cut on their leg is addressed, the nurse or doctor are the experts when directing the clients on how to take care of their wounds. Whereas, when clients come to the emergency department in mental health crisis, the same nurse or doctor may be tempted to instruct the client on how to fix the circumstance that caused them emotional distress, using statements such as, "You need to break up with this person."

During this practicum, I took the opportunity to take an online course with the Centre for Addiction and Mental Health (CAMH), sponsored by the Mental Health Commission of Canada, on understanding stigma. This training provided me with strong suggestions on how the role of a crisis worker could begin to prevent the reinforcement of oppression throughout the everyday routine of a crisis intervention. This training increased my awareness of the importance of first-

hand exploration of the needs and wants of the client, as they are always the expert of their desired outcome (please see Appendix B).

The next stage of the sequence of a crisis intervention, as described by Flannery and Everly (2000), is the focus on problem solving and the encouragement of self-reliance, which was easily plugged into the MI principles of evocation and autonomy. MI recognizes that evocation and autonomy are essential in the working relationship between individual and practitioner. Rosengren (2009) described evocation as drawing out ideas for solutions from the client, as the practitioner does not know what a specific client will need or want. The goal here is to evoke the individual's reasons and potential methods for change and offer appropriate ideas for the client to consider. The final decision on moving forward with the treatment plan is left up to the autonomy of the individual. An important element of MI is to focus on the need to draw from the client their goals, values, and desires so that they, not the practitioner, argue for why the change is required. This is not always an option, though, in cases such as an involuntary psychiatric admission. An involuntary psychiatric admission to hospital by a psychiatrist may occur when a client presents to hospital in the mental health state of a psychosis, such as with untreated schizophrenia disorders, the bipolar disorder state of mania, or as induced by the misuse of alcohol or illicit substances. In these states, a client does not have the mental cognition or is not orientated to the reality of present time and space to respond to any type of MI intervention.

The strength of MI is concentrated in the use of the skill set of OARS, open-ended questions, statements of affirmation, the use of reflection, and summary, by the practitioner (Miller & Rollnick, 2002). The practitioner does not sit with a neutral stance as the client develops either overly complex or underdeveloped plans but instead mentors, like a personal guide, assisting through the thought processing of various options, with reference to where

difficulties may appear, how to address these difficulties, which resources will be required, and evaluation of the final plan (Rosengren, 2009). During this practicum, I was able to identify an example of my success with the skill set of OARS by the response of a client, with reference to how she had been living in her home environment, who made the comment, 'Yes, I am stuck, you get it' (personal communication, anonymous, July 16, 2018). What this statement meant to me as a practitioner was that I was successful with using the skill of reflective listening by using the client's own words, providing a short summary, and reflecting back to the client, providing meaning that was representative of their unique lived experience.

The parallel of crisis principles of Flannery and Everly (2000) and MI principles of Miller and Rollnick (2002) came together and illustrated a potential alignment, which may increase future successful outcomes for crisis/intake interventions with the clients of Manitoulin Island. In an attempt to bring awareness to the community of MHC staff and to begin to suggest changes for how people function within this work culture I agreed to participate in the world suicide prevention day campaign. During this practicum, as a crisis worker, I attended a sub-committee of the main Mental Health and Addictions partners committee (members are comprised of Indigenous and non-Indigenous mental health and addictions service providers of Manitoulin Island), called the Suicide Prevention sub-committee. As a committee, they bring awareness of the suicide prevention day to the community of Manitoulin Island.

The campaign included posting their campaign posters of ideas of how people can help others who may be mentally struggling within the community and providing ribbons to wear on World Suicide Prevention Day on September 10, 2018 (see sample poster in Appendix C). The ribbon was orange and yellow and could be pinned on staff name tags or uniforms as a sign of support for suicide prevention. The colours represented the colours in the flame of a candle, as illumination of hope and light in the darkness of mental health difficulties. I participated in the

second annual World Suicide Prevention Day for Manitoulin Island by taking an active role in the distribution of ribbons and posters in both of the emergency departments of the Manitoulin Health Centres. The medical staff at both emergency department sites and my co-workers here at HSN were very receptive to this campaign and wore the ribbons in support of raising suicide prevention awareness. Participation in this global campaign at the local level of the emergency departments' medical staff and HSN mental health and addictions program staff may have promoted conversations around suicide prevention which could lead to the breaking down of negative stereotyping mindsets that hold oppression at the personal, community, and even structural levels.

**A cohesive narrative.** MI techniques emphasize creating a cohesive narrative with the individual during a crisis/intake intervention that allows for strength-building conversations that could lead to treatment compliance. Angus and Greenberg (2011) defined a narrative as a life story that, in combination with an individual's emotions, could form meaning and a sense of self. They suggested that the evocation and articulation of emotions are important in the change from a maladaptive life narrative to a more life-enhancing alternative.

Rosengren (2009) stated that reflective listening by the practitioner helps clients to organize and understand their experience. The work of the MI practitioner is not to just repeat what they have heard but rather to put what they have heard into a structure that the client can use to help solve their problems and move forward, as in 'the creation of a cohesive narrative'. The practitioner of MI intentionally uses open-ended inquiry to draw out information from the individual to aide them in their process of making sense of their experience. The Institute of Healthcare Communication (2015) stated that the goal of open-ended inquiry is to obtain the story, not just an answer, as the intervention is a search for meaning, not for facts. The ability of the MI practitioner to summarize the information they gather from the individual, who may be in



the midst of their own emotional distress, into a story has great value for personal understanding and acceptance by the client. What this practicum has taught me is that everyone has story, a past story, a current story, and a story of unlimited possibilities yet to be written.

During this practicum I learned that in order to best advocate for the client who is seeking services, I must present their detailed facts, needs, and wants offered as a cohesive narrative to the emergency doctors and co-workers so that they can understand quickly the situation of the client. I have learned that the better I can clearly, concisely, and in a short time frame of five minutes or less, present a summarization of the important details of the client's experience, which I have just heard in an hour long crisis intervention or intake telephone interview (often a scattered representation of emotions and facts), the better chance I have that the emergency room doctor or my co-workers will discuss the treatment plan I have requested.

**Focus on engagement.** MI offers something that is unique from other therapies: the focus on client engagement through the guiding philosophy of the 'spirit of MI'. Rosengren (2009) described how the spirit of MI is created with the elements of collaboration (I will walk beside you in a stance of creating a positive environment within which change is possible), evocation (I will give you reasons, potential methods for change, and offer appropriate ideas), and autonomy (I will leave decision making up to you). Rosengren (2009) stated that the intentional use of OARS within interventions and the elicitation of change talk, without the use of the spirit of MI, is not MI, no matter how skilled the practitioner may be at using OARS. Conversely, when the spirit of MI is operating, many practitioners' interventions can 'appropriately fit' within a MI framework. MI is then not a primary collection of techniques or interventions, but a series of specific practitioner behaviours directed by this guiding philosophy. It is the MI spirit that can increase the engagement process (Rosengren, 2009).

MI as a means to enhance treatment compliance has been studied. Carroll et al. (2006)

conducted a study with 423 participants, equally randomized to MI or to standard intake evaluation, in four community sites. This trial was the first to evaluate the effect of implementing evidence-based therapies into 'real world' clinical settings where randomized clinicians were drawn from the existing staff. The trial evaluated the effectiveness of incorporating MI techniques into the initial intake session of community treatment programs and found that treatment retention was comparatively high overall and that participants assigned to MI were significantly more likely to still be enrolled in the program one month after randomization. Integrating MI techniques and strategies into a single intake session at the participating community-based treatment programs compared to standard intake, enhanced treatment engagement and retention and reduced substance use within participants. It was noted that the practitioner skill levels were rated by independent raters on audiotapes of both MI and standard intervention sessions, thus suggesting that the practitioners were able to implement MI at a high and consistent level. Further, it was noted that interventions consistent with MI were implemented comparatively infrequently in the standard intervention condition.

Carroll et al. (2006) suggested that community-based practitioners have effectively implemented manual-guided approaches such as MI and underlined that even small adaptations to intake procedures in community clinics would improve treatment. While the efficacy of the training model used in this trial was not assessed directly, these results did suggest that community-based clinicians could learn to deliver MI effectively. Included in this training was the requirement to demonstrate proficiency in implementing MI by review of session tapes and the provision of consistent, structured local monitoring and supervision. This study suggested, at a community-level of intake or crisis intervention, that the MI skill set used by a practitioner, who is under direct monitoring with supervision, would enhance treatment compliance (Carroll et al., 2006). This study's structure is similar to the framework of this practicum, a practitioner

learning MI under the supervision of a faculty supervisor while conducting intake or crisis interventions in the community settings of HSN rural site, Mental Health and Addiction programs and MHC emergency departments (Carroll et al., 2006).

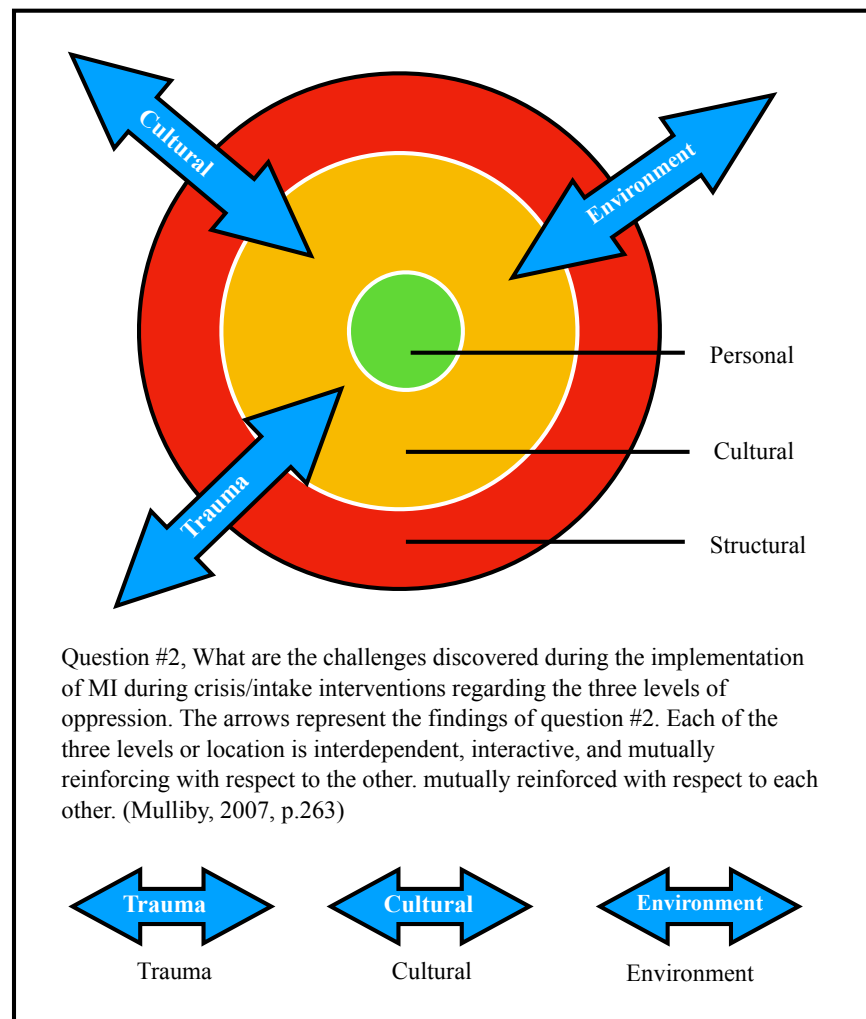
During this practicum, engagement with the faculty supervisor, Allan Chislett, was beneficial as he assisted me in helping clients navigate the personal, cultural, and structural oppression levels are experienced in HSN intake and MHC crisis interventions (please see Appendix D). At the personal level of intervention, suggestions by Mr. Chislett as to certain verbal phrases or approaches to use with clients, gleaned from his practical social work experience, were very helpful. I noted that once I began to use Mr. Chislett's suggestions, clients were more open to the process of the interview and it was easier to decrease any power differentials on the personal level of oppression. On the cultural level of oppression, it was emphasized by Mr. Chislett that it was important to not make any assumptions of the experience of someone based on the community in which they lived (i.e. there are different stereotypes of the various First Nation communities of Manitoulin). As a practitioner, it is always good practise to ask direct questions to the client to ascertain current information and not to assume your working knowledge is correct. As a practitioner it is important to have awareness and knowledge of the current trends, research, and therapies in the field of social work. Mr. Chislett, with his prior work experience with HSN, was very knowledgeable and insightful into how to navigate the system to mitigate the structural level of oppression. Mr. Chislett encouraged me to take the time I needed to orientate myself (with deep breaths) and the client (start with casual conversation or humour) prior to the intervention. He recommended gathering the required information for the crisis intervention as I needed, but in a style of my own development. This conversation served to increase my confidence and autonomy within this crisis/intake role, and I was able to implement the use of MI with my personal flare. During this practicum, I have

discovered that MI complimented the levels of crisis as depicted by Flannery and Everly (2000), developed a cohesive narrative as reported by Rosengren (2009), and increased client engagement, thus setting the client up for improvement with compliance as reflected by Carroll et al. (2006).

### **Context of the Practise Problem #2**

Practise problem #2, which examined the challenges of the implementation of MI into the intake/crisis interventions, was interpreted by using the PCS model of analysis (Mullaly, 2007). I discovered three challenges during this practicum that pertained to practise problem #2. I learned quickly that I needed to orientate myself on how to provide trauma informed care. Further, I discovered that I needed to be aware and knowledgeable of the culture of the Indigenous people who were accessing services and integrate this learning into how I presented MI. My final challenge with this practicum was the need to create adaptations to the physical space within MHC's emergency departments, in order to provide MI with crisis interventions.

Figure 3: PCS Model of Oppression with Question # 2 Findings



**Trauma.** The intense array of trauma stories that I heard during the crisis/intake interventions helped me to quickly realize that I needed to orientate myself to trauma informed care in order to be an effective worker. Using the Raja et al. (2015) trauma informed care pyramid, step one and step two, helped me to focus my attention during interventions. This pyramid suggested that the first goal of interaction with a traumatized client is to develop excellent client care and information exchange to reduce anxiety, while in conjunction, offering options that increase comfort levels (i.e. signal for increasing anxiety, orientation to process). I

did notice that most individuals after being orientated to the process of the crisis assessment did show signs of reduced anxiety, such as more relaxed body alignment.

The HSN crisis assessment form has a category called the history of trauma that lists physical abuse, emotional abuse, sexual abuse, crime victimization, or other (see Appendix E for crisis UMAT form example). I noted, during crisis interventions, that trauma experiences presented very frequently with Indigenous individuals. Indigenous individuals coming into services usually could identify with at least one, usually more than one, and sometimes all the trauma questions asked. I had to address my difficulty with asking about the trauma history of sexual abuse, especially when it was not a part of the reason for a crisis presentation. My faculty supervisor, Allan Chislett, was able to challenge my thinking and helped me to understand that when I was asking that question I might be presenting a different or incongruent presentation to the individual if I showed that I was not comfortable asking that question. Mr. Chislett assisted me by reframing this experience by prompting me to ask this question as a positive, by seeing that a client who may have experienced this trauma may possibly feel relief that someone asked that question as I may be the first person in their life to have asked. I believe implementing these changes, as suggested by Mr. Chislett, increased my comfort level as a practitioner that in turn may have cascaded into increased client engagement.

The second step in the Raja et al. (2015) pyramid focused on the importance of the practitioner being knowledgeable and understanding, recognizing that individuals living out of trauma experiences may use maladaptive coping mechanisms and, therefore, a practitioner must use a non-judgemental stance during intervention. During this practicum I had no difficulty presenting a non-judgemental stance with clients as I implemented the OAR skills of MI, largely based on my prior work experience in the mental health field. I did soon realize, due to the traditional time constraints of usually one hour maximum per crisis/intake assessment, that there

were some clients that needed more direction to contain their emotional energy. Mr. Chislett suggested a Socratic questioning (Padesky, 1993) format as an adjunct to the intervention as it proves to orient the individual back into processing the questions in their mind and out of their emotional state. Padesky (1993) described Socratic questioning as a line of questioning where the practitioner believes the client has the knowledge to the answer they are looking for, and that the practitioner needs to draw their client's attention to facts that are relevant to the issue being discussed but that may be outside the client's current focus. The practitioner while moving the client from concrete to abstract thinking will open up space so the client can now use this new information to either re-evaluate a previous conclusion or construct a new idea. I discovered during a few crisis interventions that using a variation of a Socratic question was very effective. I would ask a client to see an admission to hospital as necessary when I asked them, "Would you tell a friend, who told you something similar to what you are telling me, that they needed to be admitted to the hospital?" The times that I used this question format, clients agreed that they were in need of a hospital admission. Socratic questioning is not used to change an individual's mind but to guide discovery.

According to Poole et al. (2013), the main belief of trauma informed practice is that people can recover, and trauma informed practice is grounded in hope and the honouring of each client's resiliency. This focus of honouring the client's strengths of resiliency and hope has common ground with the spirit of MI. The belief is that the motivation for change comes from within the client and the practitioner of MI is the guide that helps the individual to decipher the best plan for themselves moving forward (Miller & Rollnick, 2002). Poole et al. (2013) stated that mental health and addictions practitioners in community or institutional settings using evidence-based practices, such as MI, are consistent with trauma informed care, in their valuing of the collaborative relationship and encouraging empowerment within the client.

During my practicum, trauma stories identified by First Nations community members of Manitoulin Island, the subordinate group, that presented at crisis or intake interventions were often more extreme, complex, and, at times, almost unbelievable in comparison to the trauma presentations of the dominant group. The dominant group of Manitoulin Island is primarily represented by white people of European decent. Mullaly (2007) stated that subordinate groups will most often suffer from the lack of adequate employment, have lower or impoverished income, inappropriate housing, suffer discrimination in the marketplace, be subject to less educational opportunities, receive inferior forms of healthcare, and be over-represented within the criminal justice system. Subordinate groups are representative of communities with the highest rate of youth suicide and deal with trauma at the community level (Mullaly 2007). Difficulties facing the Indigenous populations on Manitoulin Island include both the discrepancy of services between individual First Nation communities and between First Nations and non-First Nations communities.

The North East Local Health Integration Network (LHIN) (2016) reported that Indigenous people (the subordinate group of Manitoulin Island) access a variety of health services through Indigenous and mainstream providers located on and off reserves. The funding for health services flows to health service providers from federal, provincial, LHIN, and Indigenous Political Territorial Organizations. This vast range of funding sources between different jurisdictions often leads to inequalities in service levels, duplication or gaps in program support, and reporting pressures on health service providers who must account to several levels of government for support received. During this practicum it became evident that each First Nation community has its own unique array of mental health and addiction support resources. For example, each First Nation on Manitoulin Island has different Sudbury psychiatrists contracted for services within their community.



At the structural level, inequalities of an oppressive nature, can contribute to increased exposure to traumatic experiences at the individual and community levels. At a structural level trauma can be created, as highlighted by Mullally (2007):

These inequalities constitute structural violence in that people who experience them consequently suffer disproportionate levels and incidences of stress, anguish, frustration, alienation, and exclusion, and these factors result in differential rates of mortality (i.e. lowered life expectancy), morbidity, incarceration, homicide, suicide, and infant mortality. (p. 275)

At the structural level, oppressive inequalities can create more violent effects or outcomes upon subordinate groups within society. During this practicum, it became apparent to me that Indigenous individuals, the subordinate group, did present with higher levels of trauma experiences.

**Cultural.** Communication with individuals of the Indigenous culture during this practicum presented personal challenges, which are identifiable in the PCS model of oppression at the personal, cultural, and structural levels. As a practitioner, at the personal level, it was evident that I needed to develop a skill set to appropriately interact with an Indigenous person who may or may not have internalized oppression. At the cultural level, as a practitioner, I needed to learn current and historical knowledge of the seven Indigenous reservations of Manitoulin Island, and have a working knowledge of how these communities are impacted by program service inequalities. At a structural level, I needed to understand the historical impact of colonial federal policies that may still oppress and impact Indigenous people through social constructs such as the health care system.

During this practicum, when interviewing Indigenous people during crisis intervention and intake, I experienced challenges at the personal level of oppression that created a need to

alter how I conducted crisis/intake services with MI. During the crisis/intake interventions with Indigenous individuals, I realized that some Indigenous individuals did not understand the questions I was asking because their answers did not match the question. I began to use plainer language and began to give them concrete examples in order to obtain the information I required for intake and crisis assessments. I also learned to slow down the speed that I was conducting the interview with Indigenous individuals so to mirror their cadence of conversation. These cultural challenges that I experienced are illustrated in Smylie's (2000) guidelines on how to support Indigenous individuals in the Canadian Health care system. According to Smylie (2000), Indigenous individuals need to be supported in a respectful manner and may present with inherent feelings of distrust of written information. Indigenous individuals may believe that important cultural information (such as traditional healing techniques) are transmitted orally and are not to be written down. Symlie (2000) further illustrated that Indigenous people commonly experience lower rates of literacy and formal educational achievement. I believe I was able to present my questions in a respectful manner that increased participation from Indigenous clients regardless of their overt distrust or educational achievement.

As a registered social worker, I am committed to follow the Social Work Code of Ethics and Standards of Practice Handbook (Ontario College of Social Workers and Social Service Workers, 2008) which guides social workers on how to treat people in social work practice, including crisis and intake interventions. The Social Work Code of Ethics (2008), principle III, 3.4 states, "college members do not discriminate against anyone based on race, ethnicity, language, religion, marital status, gender, sexual orientation, age, disability, economic status, political affiliation or national origin" (Ontario College of Social Workers and Social Service Workers, 2008, p. 16).

Marginalization constitutes a basic feature of injustice and affects primarily people of colour, old and young persons, unskilled workers, and specifically North American Indigenous people (Mullaly, 2007). Mullaly (2007) stated, “these groups constitute a growing underclass permanently confined to the margins of society because the labour market cannot or will not accommodate them” (p. 266). The Indigenous population of Manitoulin Island is marginalized, not only based upon their Indigeneity but also on the fact that they constitute only 40% of the population of the island. Culturally, the marginalized Indigenous population of Manitoulin Island, as people of colour and with different physical features, are considered to have less social power than the dominant group. The dominant group of Manitoulin are people from European descent, primarily white-skinned people.

As a practitioner, it was important to spend time reflecting on how best to present myself in intake or crisis interventions. It was necessary for me to acknowledge that, in physical presentation, I have social power because of the white colour of my skin and because I represent the professional occupation of social worker. I am accredited by the visible lanyard around my neck with my HSN identity card that contains my photograph, name, and credentials as a social worker. I had the advantage during this practicum to have already done much professional self-reflection and educational training in the field of mental health and criminal justice while in my role with Canadian Mental Health Association. I am not new to interacting with Indigenous people. I have lived among, worked with, and socialized with Indigenous people as a resident of Manitoulin Island for over twenty years. I am already confident in my ability to talk with people of Indigenous descent without imposing the settler-dominant culture. I understand how the First Nation reservations function as a community, as I am already well networked in mental health and addiction social constructs.

I am able to build rapport quickly with Indigenous individuals because I do understand, from both a personal and professional standpoint, where they are coming from. I am married to an Indigenous man, with the last name of Corbiere, which is known to most residents of Manitoulin to have originated from M'Chigeeng First Nation. As part of my introduction, at the point of intervention, I do introduce myself with my married name, and, by doing this, I am usually granted some 'common ground' or at least 'curiosity' from the Indigenous client I am greeting. I have learned to be as non-threatening in my physical stance as possible by keeping a larger than average personal physical space when near Indigenous clients. For example, I would ask permission to enter into the room as a means of building a space of respect, privacy, and safety. For example, when I finished an intake with an Indigenous person, and was encouraging them to advocate to the emergency doctor what they had just described to me about how anxious they felt inside, and telling them that they can ask the doctor for medication to help if they wanted to, their response was in a low quiet voice, "Do you think the doctor will talk to me even if I am an Indian?" (Personal communication, May 3, 2018). In this moment, I was hit with two thoughts: 1) this individual felt so comfortable with me that they could ask that question; and 2) I just heard first-hand what internalized oppression sounds like. I did my best to reassure them and asked them if I could tell the doctor ahead of time what they shared with me, so that the doctor would already know how they were feeling. By doing this, I hoped I would increase the chance for a beneficial outcome when this person did, in fact, talk to the doctor. This example was a harsh reminder to me that a subordinate group does not experience the same experience that I do as a member of the dominant group. This taught me that Indigenous people may have a very different worldview, and that I, as a member of the dominate group and as a social worker, have the responsibility to advocate for equal access to medical services and to be the bridge if needed for any actual or perceived gaps in service.

During this practicum I had the opportunity to attend ten hours of teleconference training with Dr. Teresa Naseba Marsh PhD., MA, RN, RP in Indigenous Healing and Seeking Safety (IHSS) through the North Bay Regional Health Centre, Regional Concurrent Disorders program (please see Appendix F for the Indigenous Healing and Seeking Safety certificate of participation). This training helped me to understand decolonizing methodologies, Indigenous trauma, culturally sensitive treatment in the Indigenous context, treatment interventions and fundamental principles, challenges working with Indigenous populations, and the Indigenous Healing and Seeking Safety (IHSS) Trauma model. It is important that the marginalized Indigenous culture is taken into account when using MI. For example, when using OARS, open-ended questions would allow me the opportunity to hear from an Indigenous client's perspective, what life is like for them. Through reflective listening, affirmations, and summaries I can demonstrate my understanding of their words about how culture impacts their lives.

Looking at the First Nations of Manitoulin Island, from a structural level, it is important to understand their disadvantage within the healthcare system. According to the North East LHIN (2016) Reconciliation Action Plan, there are 60,000 Indigenous people in the NE LHIN, making up 11% of the total population. In comparison, on Manitoulin Island, Indigenous people make up 40% of the population. The North East LHIN (2016) reported that Indigenous individuals experience a lower health status than other Northerners. Indigenous people have higher rates of medically complex chronic health conditions (i.e. mental health disorders, diabetes), physical aging at a younger age due to multiple chronic conditions, higher rates of youth of mental illness, poor oral health, higher rates of suicide and suicide ideation, and overrepresentation as clients in addiction services across Northeastern Ontario. Acknowledging the inequalities in First Nations communities and using existing resources to build safety plans during crisis interventions or make mental health or addictions referrals was familiar to me, as I

know the key agencies that offer these resources. I know the gaps in service and I recognise that a referral from crisis intervention will help individuals obtain the service they require from their own communities in a more expedited manner. During this practicum, I was at an advantage as I already knew the oppressive structures of the hospital health care system and mental health and addictions programs and also knew how to best advocate for clients as I am networked with these social service agencies and know how to use my influence to push for services.

**Place of intervention.** The different physical spaces where crisis or intake interventions took place became a challenge during this practicum identifiable in the PCS model of oppression from personal, cultural, and structural levels. Clients are met for a crisis assessment in one of the emergency department rooms at either the Mindemoya or Little Current sites of Manitoulin Health Centre. At the Mindemoya site, there are only three rooms that have doors that can be closed for privacy, but these rooms may not be an option based on capacity level. The Little Current site has a newly renovated emergency department that does triage for mental health presentations. Depending on the capacity level at the time of intervention, crisis interventions are likely to be conducted in a room where the door can be shut for privacy. The interview room could vary from a space with a small couch in Little Current to a chair beside a bed in a cubicle divided from another treatment space by a curtain at the Mindemoya site. The emergency department is the only mental health service on Manitoulin Island that is open twenty-four hours a day and, therefore, provides mental health coverage for the hours outside the workday for the HSN crisis program. The emergency departments can be intimidating to any client, in the sense that they are very clinical, with the sterile environment of a hospital, and are surrounded by hospital equipment and supplies.

The emergency departments of Manitoulin Island could be seen as oppressive in nature as they are representative of a Western medical system. The emergency department does not

encourage a sense of a calm, non-threatening environment as it can be very chaotic, loud, and confusing when an immediate medical crisis presents. The close proximity to the other rooms within the emergency department can interrupt a crisis intervention, with noise and a viewing first hand of other patients who are presenting on stretchers or wheelchairs with physical injuries. There are a wide variety of frightening or disturbing things for a client who is already experiencing their own emotional anguish to witness, such as blood and open wounds.

During this practicum, I was able to be the power of one and offer some comforts to the individual in crisis which may not be normally offered, such as a warmed blanket, dimmed lights, advocating for medication if needed for physical pain or sedation of symptoms of anxiety, food or drink, or assisting with making phone calls to family or friends. I was able to adapt to the existing environment and bring in other means of comforting support within the limitations of the emergency department space in an effort to establish physical and emotional safety for the individuals in mental health distress.

At the cultural level, as discovered in this practicum, Manitoulin Health Centre is the only location used to provide crisis services, including risk assessments, to assist the emergency doctor in making referrals to psychiatric services in Sudbury. These rural community hospital sites, as a medical construct of the society of Manitoulin Island, do offer one room at each hospital as a designated space for Indigenous people to meet as a family and/or to use for their cultural ceremonial practises (i.e. smudging).

HSN offers interview rooms as a place of intervention for intake interventions or over the telephone that is an accommodation option for clients due to the large geographic area of Manitoulin Island and the lack of public transportation. The interview rooms at HSN are private but also located within a hospital setting which is different from other HSN offices that are located in buildings within the community, making access more accessible and inviting. HSN

offers intake interventions over the phone as a means to break down the local access barriers to service due to the large distances between communities and lack of transportation.

During this practicum, I attended the Mental Health and Addiction providers committee, which represented mental health and addiction services across Manitoulin. This committee included various providers such as Indigenous mental health and addictions providers, HSN providers, private practitioners, district social service board representation, NE LHIN members, Manitoulin Family Resources representatives, Manitoulin Health Centre employees, and Victim Service program providers. This is a great avenue that providers are using to address community issues. Recent accomplishments included developing a drug strategy for Manitoulin Island, implementing the OPP mental health screener mandate, and advocating for funding from the NE LHIN for positions to fill committee identified system gaps.

On a structural level there are challenges for space due to the lack of availability of regional psychiatric beds within designated hospitals and within community programs in the mental health and addiction service system. There are constant crisis situations at HSN with overcapacity situations. People on stretchers in hallways at HSN are very commonplace. There is a new Strategic Plan being developed for HSN for 2019 to 2024 that will address the lack of psychiatric beds. It will also start the process of redesigning its mental health and addiction programs in hospitals and communities in order to offer an improved continuum of support services for mental health and addictions consumers.

**Conclusion.** The main challenges of trauma, culture, and environment discovered in this practicum, when viewed from the lens of personal, cultural, and structural oppression, can be positively affected by the use of MI. It was discovered that universal trauma care is not being fully implemented at the MHC hospitals when compared to the trauma informed care pyramid by Raja et al. (2015). During this practicum, step one and step two of the trauma informed care



pyramid was successfully implemented with the understanding of the health effects of trauma and the offering of client-centred care and communication. It is important to be cognisant of the present and changing trends of Indigenous culture and how to best offer services in a respectful manner in order to establish effective communication for individual client care within mental health and addictions programs. The challenge of finding a calm and private place to interview clients in emotional distress was an issue within the emergency departments of MHC. HSN mental health and addictions program offers private interview rooms but is still offering community programs from the physical space of a hospital, which is not a conducive environment to support community programs. Regardless of the challenges that were presented during this practicum, MI was successfully implemented with crisis/intake interventions. In summary, according to Lundahl et al. (2013), MI can profitably be delivered by a variety of health care professionals with a small investment of time in medical care settings in a range of unique formats and time frames for individuals of diverse ages, gender, and ethnicities. Lundahl et al. (2013) remind us,

The take home point is: No matter what your professional training or where you work, if you can devote a small amount of extra time with your patients to build relationship and evoke change talk, you can expect 10-15% additional improvement across a wide variety of behaviors and medical outcomes. (p. 166)

This illustrates how effective MI can be with crisis/intake interventions regardless of what challenges may be present. MI with crisis and intake presentations offered more than a completed referral form. It gave clients an opportunity to be listened to, validated, understood, and provided a safe space to re-evaluate their life narrative that had the potential to mobilize them forward to improved mental health outcomes.

### **Chapter 3 – Process of Advanced Practicum**

To fulfill part of the requirements for the Laurentian University M.S.W. program, I engaged in an Advanced Practicum (SWRK 6024R) from May 23, 2018, to August 15, 2018. The practicum setting where I completed the required 450 hours was at Health Sciences North, Mental Health and Addictions Program (MHAP), Manitoulin site. In this chapter, I will begin with a description of the Advanced Practicum environment, agreement with agency, importance of social work supervision, training plan, and ethical considerations.

#### **Description of the Advanced Practicum Environment**

For the duration of this practicum, HSN-MHAP, Manitoulin site, leased rooms on a non-patient floor of Manitoulin Health Centre, in Little Current, Ontario. HSN programs provided adult and seniors mental health treatment, adult addiction treatment, and intake and crisis intervention for individuals over the age of sixteen. The treatment and recovery programs include intake assessments, crisis risk assessments, mental health treatment using cognitive behavioural therapy, senior mental health cognitive functioning assessments, first episode psychosis intervention, prenatal mental health, mood and anxiety educational group sessions, and psychiatric consultation support services. This rural site supports all clients over the age of sixteen residing on Manitoulin Island who request program services. The mission of HSN is to improve the health of northerners by working with partners to advance quality care, education, research, and health promotion. HSN's vision is to be globally recognized for patient-centred innovation. The values that HSN supports are excellence, respect, accountability and engagement (Health Sciences North, 2017).

#### **Agreement with the Agency**

Prior to accepting this new work role as a crisis/intake worker, I discussed the process of placement with Francine Boudreau, MSW Field Coordinator. She agreed with my intention to

use this temporary, full time contract position with HSN as my Advanced Practicum. I notified Amanda Conrad during my interview of my intention to use this work position as a practicum and she agreed to support this endeavor. I was on an educational leave from my full-time position at Canadian Mental Health Association Sudbury-Manitoulin (CMHA-SM) as the Court Outreach Worker/Rehabilitation Practitioner in order to complete my MSW. As an employee with CMHA-SM, for the last fifteen years I worked in this same location, in this shared office space, with the employees of HSN Little Current site.

### **Supervision**

Amanda Conrad, MSW, RSW acted as my direct Clinical manager, who was responsible for my performance appraisals but due to her workload was unavailable to supervise this placement. Mr. Allan Chislett, MSW, RSW (see Appendix C) fulfilled the role of Field supervisor for Laurentian University, for the duration of this practicum as I implemented the theory of MI into my social work practice. I met with Allan for three sessions at his home office in Mindemoya, as the agreed upon private space. We reviewed and discussed my progress during this practicum. Mr. Chislett was available for telephone contact when an urgent matter arose.

### **Training Plan**

As a contractual employee of HSN, I completed the orientation process for the crisis/intake position and met the occupational health requirements prior to employment. Nancy West-Cranston, Team Leader for Manitoulin-site led my orientation training and was my HSN contact person for the duration of this practicum. I had the opportunity to learn from my HSN co-workers at weekly intake meetings and have elicited feedback during my contractual employment in this role of intake/crisis worker. As an introduction to MI prior to this advanced practicum I attended a MI-based training, presented by Sherry Price, DDS, MSW, RSW, called Choices and Changes: Clinical Influence and Patient Workshop. This was provided through my

employer for health care providers on March 9, 2018, at Huntington University. This workshop was sponsored by the North East Chronic Disease Self-Management Initiative and provided a solid base of MI learning for preparation for this practicum (please see Appendix G).

### **Training Goals**

My goals throughout the practicum were to enhance my social work skills by facilitating motivational interviewing during intake/crisis interventions, work as part of a multi-disciplinary team, attend clinic supervision, and diligently critique my social work practice with reflective journaling. I completed mandatory training on-line: Privacy and Information Security—Clinical User Training, Clinical Viewer Training, Code White, Social Media Policy, Accessibility for Ontarians with Disabilities—Customer Service Standard, Ministry of Labour Worker Health and Safety Awareness in 4 Steps (please see Appendix H-N). I requested and was granted permission to attend a one-day workshop on April 30, 2018 by Dr. Phillip Resnick, M.D., Professor of Psychiatry (Case Western Reserve University, School of Medicine, Cleveland, Ohio, USA) on Risk Assessment for Violence (please see Appendix M).

### **Ethical Considerations**

As a registered social worker with the Ontario College of Social Workers and Social Service Workers (registration #816155), I abided by my code of ethics and standards of practice (OCSWSSW, 2008). As an employee of HSN, I abided by my rules of confidentiality, all limitations of confidentiality, and Personal Health Information Protection Act (PHIPA) legislation that guided my social work practice.

All the clients that I supported in this role of intake/crisis worker came to intake/crisis services out of a need for stabilizing their mental health distress and/or help with learning new ways to cope with mental health or addiction circumstances. As the clients who came for support

represent a vast population of different backgrounds, cultural identities and competencies I, as a part of my employment requirements, obtained a clear vulnerable sector police check.

Miller and Rollnick (2002) reviewed motivational interviewing for potential ethical considerations that may arise when treating clients and categorized them into three: compassion, opinion, and investment. They suggested that a compassionate practitioner would have the client's best interests at heart. If a practitioner comes to the place, through burnout or otherwise, where their actions became rote or an intellectual exercise, Miller and Rollnick (2002) suggested that the practitioner should leave this line of work. Miller and Rollnick (2002) also suggested that a practitioner withhold sharing their opinion about the outcome of the individual's circumstances, as their opinion is really their judgment call as to which choice best serves the client. Investment, according to Miller and Rollnick (2002), refers to what the practitioner has to gain or lose depending on which choice a client makes. This can refer to tangible interests, such as job performance based on engaging certain numbers of individuals into service, or over identification with the issues of the individual. Overzealous behaviour in the promotion of particular choices for individuals may equate outcomes with practitioner personal worth and competence as they became overinvested in the choices that clients have made. I remained neutral to what decisions clients made regarding their choice of treatment, as I respected their right to make their own decisions based on their comfort levels at the time.

Miller and Rollnick (2002) further suggested guidelines for ethical practice that I have used as check in questions during my work performance. They suggest that practitioners be self-reflective: a) When you feel ethical discomfort, clarify the individual's aspirations and your own; and (b) When you feel that your idea of what represents an individual's best interest does not align with theirs, consider and share your agenda, making it clear they are your own concerns and aspirations for them. It has been cautioned not to use MI as a practitioner when there is

personal investment in a particular individual's outcome or your role includes coercive power that can influence the individual's behaviour and outcome (Miller & Rollnick, 2002). As a social worker and HSN employee, I did not have to report any conflicts of interest, as no opportunity presented during my practicum where I would have been in a conflict of interest situation. I did not have to advise my Team Leader, nor request another counsellor to conduct any of the intake or crisis interventions for the client, as I did not have any personal investment in the outcome of any said interaction.

I did encounter an ethical issue while I was in the role of intake/crisis worker. I had received training with HSN on their ethical decision-making processes at the General Orientation on January 8-9, 2018. I was guided by policy and procedures on ethical matters. I did bring forth the ethical issue to my Team Leader when the matter arose and was helped through a decision-making process suitable for an Advanced Practicum MSW student.

## **Conclusion**

In conclusion, there has been significant research in the past two decades regarding the efficacy of MI and the pairing with other modalities of treatment. Despite the success of MI in a variety of settings in addictions and healthcare, there is little literature on MI for individuals residing in northern communities accessing crisis intervention services or with individuals accessing intake into mental health or addiction services. Throughout this practicum, my goal was to develop and acquire a skill set in MI that would benefit the clients interviewed by me.

## **Chapter 4 – Reflective Analysis of My Social Work Practise and Supervision**

Throughout the research that I have reviewed and within the field of social work practise, it is clear that social workers recognize and are confronted by oppression at the personal, cultural, and systematic levels as they develop professional competency in delivering effective service to diverse populations. “Competence depends on habits of mind, including attentiveness, critical curiosity, self-awareness, and presence” (Epstein & Hundert, 2002, p. 226). Sheppard (2000) stated that successful social workers are those that have developed a reflective practice, in that they are “highly analytic and critical, and this permeates all aspects of their work” (p. 481). Reflective practice is critical to the practice of social work according to the OCSWSSW. In their Code of ethics and standards of practice, self-evaluation is discussed:

2.1.5 As part of maintaining competence and acquiring skills in social work or social service work practice, College members engage in the process of self-review and evaluation of their practice and seek consultation when appropriate. (OCSWSSW, 2008, p. 12)

The purpose of this chapter is to provide a review of reflective practise, an analysis of my social work practice with summaries of the stories of people that accessed crisis/intake services, and reflection on the supervision I received during my Advanced Practicum. This section begins with a discussion of journal logs and logging of supervision notes and how they have enhanced my MI learning. This will be followed by sections on my learning about social change, and the value of clinical supervision in social work practice.

### **Journal Logs to Enhance MI Learning**

As a means of ensuring reflective practise that emphasized critical thinking within my practicum, I maintained a journal and logs. I maintained these written forms of documentation to provide a practical means to learn the skills of MI and develop the links between MI theory and MI practise during this practicum. For example, I used my journal form that included definitions

of the spirit of MI and its principles with areas to fill out regarding the breakdown of the eight stages of MI (please see Appendix O). These journal logs served as an effective place to specifically record and reflect on what I heard from clients during a session, and how I responded with MI during a session. Over this practicum, I was able to identify when I needed to respond to clients with an open-ended question and when I needed to offer affirmations. After I completed an intake/crisis session, I would fill out the journal log and review the areas that I did well or see areas that required improvement. I would compare my questions and responses from my journal logs to the concrete examples from a practitioner workbook (Rosengren, 2009) to validate my MI learning. Since I did not have a mentor who could observe my MI skill performance in session, I relied on the body language and verbal responses from the clients to guide my MI skill success. I was able to identify, by the facial expressions of the clients I interviewed, whether I thought an affirmation was effective. I saw a softness appear on their facial features or heard pauses in their voices during conversations as clients were processing the affirmation I had given. If the affirmation I gave was not appreciated by the client, they would usually make a negative comment back or joke about the validity of the affirmation. I would then take this new information and listen closer to understand what they were saying in order to find a more meaningful affirmation that resonated with what was of importance to them. I listened carefully and remembered comments that clients made about past successes and brought it back into the conversation to relate it to present events to offer a new perspective on the topic.

For example, I drew on the hard work an Indigenous person did to successfully access mental health services and used it as an introduction to what he could accomplish next in his life, so I asked the question, “So given all the hard effort you made today to successfully get help, what do you think you will do next?” This question was formed as an elaboration with the intent to evoke change talk. I used his success story, drawn forth from what he said and did, and held it



up for him as an observation. The answer I received was “quit drinking”. This was an opening of the door with this Indigenous person to allow him to begin to look at motivation for change in the direction of quitting drinking (personal communication, anonymous, December 15, 2018).

I also learned to offer clients’ ideas back to them in a more complex reflection. For example, during a crisis intervention with a client, I used a double-sided reflection such as “you mean that one part of you wants to die or have it all end but there is another part of you that wants to find the help to make things better”. This double-sided reflection, using the words of the client that I was hearing during the intervention and reflecting back to them, was successful in offering clarity for the client to see both sides of their inner conflict. The use of this very structured practise of my MI journal log increased my skill sets for MI and confidence in my social work practise.

### **Learning Through Logging Supervisory Meetings**

As a means of record keeping for the purpose of strengthening my reflective and critical social work practise during this practicum, I maintained a journal of all meetings and telephone contacts with my field supervisor, Allan Chislett, and my professors, Dr. Leigh MacEwan and Dr. Tanya Shute. This supervisory meeting journal became very important to me as a means of documenting my progress and highlights of learning during my practicum. I would reflect back at a later time on many of these discussions and spend more time thinking about the depth of what I heard about theory and how it related to my social work practise. For example, during a telephone discussion with Dr. Leigh MacEwan and Dr. Tanya Shute (personal communication, June 5, 2018), I shared that I was surprised to hear so many traumatic stories from the clients during crisis/intake interventions. Dr. Tanya Shute gave me examples of how to think differently about the hard emotional stories I heard and encouraged me to actively release all of them at the end of the workday.

I realized that I needed to actually do something about one specific traumatic story that was held in my mind, still secretly ruminating. I was blindsided by one story in particular as it evolved from a simple question about family history. I was silent, as I had begun to visualize the details of the story and add my own details, making this story into a movie in my mind's eye. This experience taught me that I needed to learn more about the impacts of trauma and learn how to manage its impacts on me.

Immediately after this intervention, I shared this experience with a seasoned mental health worker. He was able to normalize some of the emotional impact that I was still feeling from the session, but he also shared some of the horrific stories he has heard throughout his career. Although at the beginning of the conversation I felt some initial emotional relief, I soon began to feel a sense of hopelessness, hearing the commonalities between the story I just heard and the experiences of the seasoned mental health worker.

I realized after this incident that there are no specific internal mechanisms within my place of employment for me to deal with the impacts that trauma stories may have on me in the future. If I decide to continue in this type of occupation, I know that I will want to access an employee assistance plan or a private counsellor for support in order to effectively do this work and mitigate any unforeseen negative impacts. Allan Chislett mentioned that he reflects on the impacts that his social work practise may have on his own mental health using questionnaires linked to the service he provides that he completes on a yearly basis to avoid caregiver fatigue. I acknowledged the need to create my own wellness plan to reduce the negative impacts of listening to traumatic experiences from clients or co-workers moving forward.

I developed a wellness plan that I implemented to protect myself from any future impacts of negative emotional stories that I was witness to during client interventions. I decided to make time daily to release the traumatic stories I heard every day, so I would not let them

become fixated in my mind, impact my emotions, or affect my future behaviour. Since that conversation with my professors, I have stopped myself from building a picture in my mind's eye of the traumatic events I hear, and I do not let the voice of the client stay in my thoughts. I actually have begun to let go of the details of the crisis intervention once I have completed the crisis intervention report. I shred the rough notes written during the intervention as a ritual of letting go of that client specific information. I have developed a mental wellness routine of walking home for lunch, which increases my physical activity level, increases my exposure to fresh air, and provides me a break from my physical work environment as a means to ground myself with a mental release and re-focus.

### **Critical Reflection for Social Change**

Fook and Gardner (2007) define critical reflection as “unsettling individual assumptions to bring about social changes” (p. 16). This structured the concept of critical reflection for me as I learned to link theory to practise during this practicum. Fook & Gardner (2007) emphasized critical reflection as something deeper than the popular notion of ‘thinking’. Their definition included a need for the reflective practitioner to think about their clients within their social context and to make links between the client and society, both in theory and practise, and linked change awareness with change action. For example, during this practicum, I was able to glimpse into the transportation difficulties that many on Manitoulin Island experience when trying to access mental health crisis services. Hitchhiking from one place to another in a Northern Ontario winter to access mental health services is something that I would not have thought to be a practise. I was able to reflect on these situations, as suggested by Fook and Gardner (2007), and extinguish my belief that all Canadians have equal access to mental health care and recognized that access to mental health care is not the same for everyone. It is through this reflective

practise that I became aware of the need for action so that mental health services are accessible when they are needed in a mental health crisis.

Fook and Gardner (2007) described the issues that practitioners face in critical reflection in the field of social work practise as feelings of tension between values based professional practice and the economically and technically formal organizations, resulting in the need to find ways to continually develop knowledge and practise that fit with this ever changing and complex context. During my practicum, I did experience feelings of tension and anger when someone experiencing an array of symptoms of depression presented in mental health crisis for a second time in three days, without any current suicidal ideation, and was not granted admission to hospital. This situation led me to spend time in deep critical reflection of myself within my role, as I had uncomfortable feelings of not sufficiently advocating on behalf of this person although I thought I did my work diligently and expressed the concerns in my written report. Another example, was that someone presented to the emergency department with depression and no current suicidal thoughts and was also discharged home. The next day I received a telephone call from a Sudbury crisis worker asking questions about this same individual, as the person had presented to the crisis department in Sudbury, and this worker was able to assist them with a psychiatric voluntary admission by a psychiatrist. I learned that those in mental health crisis have a better chance of admission to hospital if they present in Sudbury, as there are psychiatrists available for assessment that have the authority to admit them to hospital under a voluntary admission.

According to OCSWSSW Code of Ethics and Standards of Practice (2008) I can fulfill a role in “the development, promotion, implementation and evaluation of social policies aimed at improving social conditions and equality” (p. 7). This taught me that there is a difference in the process of how clients in crisis are evaluated for admission to hospital. As a goal, based on this

discrepancy or gap in service, I have a duty and a desire to align the rural sites to operate similar to the urban hospital site if at all possible for movement toward equal access and treatment for clients presenting in crisis. I used Fook & Gardner's (2007) definition of critical reflection. When a circumstance was not successful from my perspective, I spent time in deep reflection on how to make the required changes to how mental health care is delivered to residents of rural communities. Rather than following the common thinking that the decision was out of my control, that there was nothing I could do, I took another route. After critical reflection, I decided that I will always find a way to talk to the emergency doctor in person to advocate for the clients as I think it may not be as powerful when the doctor only reads my crisis intervention plan. Knowing that the emergency room department can become very busy, a five-minute conversation is always quicker than reading a nine-page report. Therefore, I must make myself available during that opportune five-minute window.

Fook and Gardner (2007) reported that within the context of critical reflection, there are often two different perspectives, one coming from the context of the practitioner and the other coming from the organization. During critical reflection, a practitioner may experience a sense of powerlessness linked to uncertainty, the fear of taking risks outside the work role, and of the increased complexity of the clients' presentations for service (Fook & Gardner, 2007). The worker may feel the impacts of the organizational response as a pressure to work to rules and procedures, generate increased paperwork, and focus on the parts rather than the whole (Fook & Gardner, 2007). For example, I was asked to assist with a meeting with a family. It was a difficult situation where I was uncomfortable participating because I did not think I had sufficient social work experience. I felt unprepared and thought that the outcome was unpredictable at best. I contacted my team leader by telephone and it was decided that this request was outside the role of crisis/intake worker. The meeting occurred without my

participation. This incident made my commitment to my social work code of ethics and standards of practise much more prominent in my thinking as I could have so easily risked my accreditation by doing work outside my scope of practise in order to help. As I work in rural hospital sites where there is a lack of specialist support, there may be times in the future that I will be called on again to assist outside my scope of practise and will have to refuse to assist again based on adherence to my College.

I was able to use reflective practise during this practicum. I have learned a new importance that reflective practise has to offer for social workers. I will carry the use of reflective practise and MI forward in my future social work practise.

### **Clinical Supervision**

In this position of intake/crisis worker, it became very evident how valuable supervision was for the development of a critical analysis and reflective practise. This position was supervised by the team leader of HSN for everyday policy and procedures and practise implementation. Ms. Nancy West-Cranston was available for process and clinical questions based on her availability. Although Ms. West-Cranston offered emotional support at times and was available for everyday process questions, the scope of her position did not include any supervision. I felt supported with the administrative pieces of this work position but would have preferred a more formal supervision format, with opportunities for performance feedback, direct teaching, or supportive mentoring. I did job shadow a crisis worker at the Crisis Intervention Services at Sudbury Mental Health and Addiction Centre—Cedar Street, for one day and found that beneficial to my learning, but it was still a challenge to return to my site as the only crisis worker without the support of peers doing the same crisis work. I had to self-teach this position as there was no one on this site who was familiar with all the job duties of this position. The worker with that knowledge was off on a leave and unavailable to provide me any orientation.

Clinical matters that could wait would be presented at the weekly team intake meetings for discussion, review, and for group consensus. For example, I brought up an issue about the procedure for informing doctors around re-directing a referral to another service. As a group we discussed the best practise for the clinic and decided together on a standard process for future practise.

Ms. Amanda Conrad is the Clinical Manager for all the rural Mental Health and Addiction sites and is responsible for the crisis/intake position's yearly work performance appraisal. I did not have a work performance evaluation during the time of this practicum. There was a new practice of communication with Ms. Conrad, Clinical Manager, that evolved over the time of this practicum. This included our team calling in to her at her office in Sudbury for quick information updates in what is formally called a 'weekly huddle'. Ms. Conrad did attend our intake meetings in person on a monthly basis and kept our site abreast of any changes to the Mental Health and Addiction programs and any mandatory training. HSN offers mandatory training, primarily of new policies or procedures on-line through learning modules, as they move forward with the new Accreditation Canada standards.

As Karvinen-Niinikoski (2016) suggested, supervision can be used as a forum for reflection, allowing social workers to reflect on their own experiences and emotions. Allan Chislett was my Field supervisor for the duration of this practicum, providing three sessions of support and availability by telephone on an as needed basis. I found that supervision with Mr. Chislett did offer me a forum for reflection, which allowed me to reflect on my experiences, emotions. Through this process, it helped to increase my confidence and deepen my awareness of my social work practise. He guided me as to how to implement social work theory into daily practise. He offered techniques on how to ground myself and how to ground clients prior to the start of the session. For example, Mr. Chislett reinforced that it was important to prepare by

grounding yourself before meeting with the client, done simply with a few deep breaths to attune oneself to the present moment. Mr. Chislett stated, as a practitioner one should observe and note visible behaviours, such as relaxation, softening, and increased connection or regulation and then provide this description back to the client, followed by a question about its significance. I adapted a question from the work of Heller & Lapierre (2012) and asked, for example, “I notice when you are talking about your grandfather, you are smiling. What are you feeling right now?”

Mr. Chislett, in his clinical social work supervision, shared knowledge with me about current findings with neuroscience and its connection to the brain and how these discoveries are impacting how we do social work, providing concrete examples of how trauma affects the brain in traumatized clients that present to the hospital in crisis. Understanding how trauma affects the developing brain can yield insights into the subsequent impairments in memory processing and the inability to cope with stress. I learned that traumatized clients have difficulties regulating their emotions and often come into the hospital to have their extreme emotional states regulated. Mr. Chislett reflected on his experience in social work as to what works and does not work for traumatized clients. He referred me to recently published books for insight (*Healing Developmental Trauma*, by Heller & LaPierre, 2012 and *The Developing Mind*, by Siegel, 2012). Mr. Chislett was available by phone for me during my practicum when I had the question of, “When can a traumatized person expect to be able to start trauma treatment after the trauma has occurred?” He responded by telling me that they could begin in a few days, as soon as they are out of their shock response. Being able to talk to Mr. Chislett, when I really needed to know that information quickly, before the start of the intervention with this traumatized client, was priceless to me. The keen interest that Mr. Chislett took in his own social work practise showed in his work ethic and the contribution he is making to the field of social work by providing professional service to the clients of Manitoulin Island.



Upon critical reflection of the value and accessibility of supervision with regard to the development of MI during crisis/intake interventions I did discover some areas of concern. I realized there were several challenges. Allan Chislett, as a Field Supervisor, practiced a half an hour away from my work location, and direct contact with him was at an off-site location. As I found my three meetings with him very valuable, I believe that had he been a supervisor on site, I would have accessed him more often for guidance, which would have increased my learning. As the work of MI and the learning of the eight stages of implementation mastery took time and practise, I would have benefited from accessing a MI coach or trainer to gain immediate feedback during my learning sessions. It would have been advantageous to have received direct feedback on how I used MI in client interventions. I believe if I had an on-site MI champion in the workplace I would have benefited by this mentorship. I would have learned quicker with observation of my work with clients during supervision. During this practicum I relied on myself and my interpretations for my learning. As I learned MI independently, I missed the input from others who may have seen things that I did not recognize as the new learner of MI. I also had times when I was unable to report in my journal log, as there were times that this crisis/intake position did not allow time for reflection. I do find learning in a group format easier, and, therefore, group work would have benefited my learning. This job itself is a position that works in isolation with no direct peers with similar work duties resulting in it being more difficult to obtain constructive peer feedback for increased learning purposes.

During this practicum I was able to use the responses of the clients during the sessions as a means of constructive feedback that helped me change my future interventions. For example, during a telephone intake with a client who requested mental health support services and was very upfront with their request that they preferred a (gender) counsellor. This statement had me change how I offered mental health services in this position as the crisis/intake worker, as I heard

this bold statement telling me that people may have a preference to the gender of their mental health practitioner based on their past experiences and comfort level. As an intake worker, I needed to offer gender choice as an option up front. This was not done in this position prior to me. I advocated for this change at an intake meeting, given we need to accommodate the needs of all clients coming into service with the choice of the gender of their clinician, not just the client who is requesting it. The staff at the intake meeting agreed with my request.

As Karvinen-Niinikoski (2016) suggested, supervision can be used as a forum for reflection, allowing social workers to reflect on their own experiences and emotions. With a critical reflection practice, they may begin to understand themselves in the wider context of the workplace, community, and society, and thus look for alternative methods of reaction, action, and agency (Karvinen-Niinikoski, 2016). Mr. Chislett provided guidance and support for me to deconstruct my emotional experiences and challenges, and the ability to understand and reflect in the wider context beyond the hospital walls. I questioned the impact that social workers have on society and the impact I had on clients presenting to the emergency department in emotional distress. I understood that the difficulty with this frontline position is that I did not receive the knowledge of the outcome of the clients I helped as both crisis and intake interventions are a one-time intervention. As a crisis worker, I saw the client in their deepest distress and pain and that is what I remember. Did the person get help when they were admitted to hospital? Did they connect with psychiatry? Did they get proper medication? Are they functioning better? These are the unknowns, as this information is not shared as the clients move forward to access community mental health resources. I acknowledged that the clients presenting to the emergency department in crisis can be at their worst temporary mental health state. I knew that this state would not be their final outcome; their mental health state always has the potential for improvement. I believe

it is important to not see the client in crisis as a permanent image; it could be a first step to hospital admission and into future mental health and addiction program support services.

### **Conclusion**

Reflexivity and supervision during this practicum were key components to my learning. I had to consciously make time to dedicate toward my journal log entries and supervision journaling and focus on the reflection of the social work I was doing. This required a shift in how I worked. I had to slow down and commit to this new practise. This was new to me as my previous work at Canadian Mental Health Association was very community based, with extensive driving between communities and the need to constantly prioritize my workload based on the change of daily or criminal court demands. In comparison, this intake/crisis position environment was in an office or emergency room department, which left me at a desk and more available to conduct a reflective practise. I can say that by carrying out a reflective social work practise to the degree as I have done while incorporating MI into intake/crisis interventions and learning new skills during this practicum, I now recognize the necessity of this practise. As social workers, without time to reflect on the work we do, how it impacts us, the clients we serve, the programs we represent, and the communities we serve, we remain unaware and open to the negative effects of working within the mental health field. This reflective practice is now part of my practice moving forward. I will not allow the pressures of organizations or other external pressures take over how I do my work.

As a member of OCSWSSW, and a social worker practising in the field of mental health and addictions, I find it of grave importance and my responsibility as a social worker to advocate for equal access and equal treatment for all clients in need of mental health or addiction support services. As a social worker, reflective social work practise has the ability to bring awareness of system deficits to light and into the social context where change can happen. I plan on using a

reflective social work practise to increase my professional development and to determine where I can best assist as a social work advocate.

## **Chapter 5 – Conclusion**

My objective on May 23, 2018, at the beginning of my Advanced Practicum, was to become a skilled and competent social worker in the application of MI with clients accessing intake/crisis programs on Manitoulin Island. I engaged in an Advanced Practicum from May 23, 2018 to August 15, 2018, at the HSN, Mental Health and Addictions program at the Manitoulin site as the intake/crisis worker on a contractual basis. In order to achieve my goal, and increase my knowledge base, I completed a comprehensive literature review. What I found was that MI was an evidence-based practise with a vast range of literature to support its broad efficacy. I discovered Miller and Rollnick's (2010a) eight stages of learning MI and Rosengren's (2009) practitioner workbook that simplified my journey to enhance my skill set in MI. Although the principal goal was to deepen my skill set in MI to enhance engagement during the intake/crisis processes, I have further gained a greater understanding of the complexities of the mental health and addictions care system on Manitoulin Island and the needs of clients who access these services. I have learned the value of a reflective social work practise as noted in Chapter 4. I will carry this forward in my professional development and to the future clients I serve. In this chapter, I will reflect on my overall discoveries during this practicum and how they relate to Emmons & Rollnick's (2001) report on MI in healthcare settings and address future implications for social work practise.

As an employee with CMHA, I did have exposure to MI training workshops, which were beneficial. But, like most new training, if the information is not applied in everyday practise, it can remain as forgotten knowledge stored away on an office shelf. This practicum had me focus daily on my intervention questions, responses, and my effectiveness with engaging clients in the intake/crisis interventions. I have been able to spend a lot of time learning MI in my everyday practise. I am still amazed at how much better I am at listening, observing, and eliciting information from the clients I interviewed during this practicum because of MI.

The opportunity of this practicum brought me close to clients in distress on Manitoulin Island. This granted me a glimpse into their life histories and experiences within the mental health and addictions care system. Through this practicum I became more aware of a few of the challenges experienced by mental health and addiction clients living in a rural area such as a lack of transportation, difficulty with accessing specialists, and a lack of immediate support services. I was able to identify a need for an increased inclusive trauma informed care structure within the MHC emergency departments and the mental health and addictions program in general as most clients presenting for services have experienced trauma on various levels. As a social worker using reflective practise, I have begun to question the inequalities of accessing rural vs. urban hospitals with regards to accessibility to psychiatry services.

I witnessed oppression existing for clients at the personal, cultural, and structural levels as elaborated in Chapter 2. This brought new awareness to me to continue to address and challenge my own oppression as it exists in my own daily practises. A reflective social work practise with clinical supervision will increase my observation and understanding of oppression.

I identified and agreed with Emmons and Rollnick's (2001) overview of key issues that are likely to arise when adapting MI to health care and community health care settings such as: time constraints, client vs. practitioner agendas, adjunctive strategies needed for supplementing MI, and more MI trained practitioners. Interventions in the mental health field are generally an hour in duration and any longer than this time is usually due to high levels of emotional distress of the client. I discovered an hour of time with a client is long enough to obtain the information required and begin to elicit the conversation for change but does not allow time for building a commitment or a plan for change. The outcome of interventions, whether crisis or intake, would usually end with an agreement to engage in further treatment services with my hopes that their desire for change will remain and will flourish with the new assigned worker.

For example, what I discovered was that I was able to engage clients into agreeing to services at their time of emotional distress but occasionally, once these services were offered by the new practitioner, the client declined service. I felt frustration with this outcome. I knew that there was a possibility that there could be a difference in presentation of services to the client by the new practitioner. By not using a skill such as MI, it may have been more difficult to engage the client and get them to further commit to services. I recognized that clients with mental health and/or addictions concerns are willing to accept help at their vulnerable times of need but are more reluctant to accept services once they have moved on past this point. I recognized that mental health and addictions issues are unique to each client.

The clients vs. practitioner agendas were very evident when it came to meeting clients at the emergency department. As emergency room medical staff was trained in addressing medical emergencies, they all may not have the skill required to evoke information from the client in distress to determine a mental health and/or addiction emergency. The Manitoulin emergency room staff may be comfortable offering physical stabilization and medications to clients in distress but may not have the time to address mental health concerns. This issue could be addressed by offering a new mental health and addiction support program in a community setting, such as the one Sudbury HSN has implemented. This is a drop-in crisis centre program apart from the hospital at the mental health and addictions program offices in the community, on Cedar Street, Sudbury.

As for adjunctive strategies for implementing MI, I found it to be necessary in brief MI interventions, whether crisis or intake, to start by identifying goals but more client intervention time was required to build next steps towards change goals. As a practitioner, I will be directive in focusing on particular questions and be client-centered when eliciting a response from them. I

discovered there needs to be more follow-up sessions to complement the start of MI, as it begins to move into the shaping stages for change.

Another concern discovered during this practicum was that not all staff were MI trained or incorporating MI into daily practise. Emmons and Rollnick (2001) stated that all staff needed to be trained in MI, and that it is possible to do so. Emmons and Rollnick (2001) described that a too tightly structured method will fail to honour the uniqueness of the client, and one too loosely structured will be difficult to evaluate and would leave more practitioners floundering. Emmons and Rollnick (2001) described a tension between science (emergency departments) and clinical practise that will not be easily resolved by asking practitioners to deliver MI as just a simple dose of intervention to be used in a perfectly standardized manner. Emmons & Rollnick (2001) stated that there is middle ground where MI and its training can meet the needs of both parties. They determined that MI is complicated by the need to have standardized intervention that can be rigorously evaluated. "The intervention, being based on therapeutic relationship must be evaluated on two levels: skill acquisition of practitioners and behaviour change of clients. Neglect of the former will render the latter unlikely to take place" (Emmons & Rollnick, 2001, p. 73). This speaks a lot to the fact that MI is a counselling style with a need for the MI spirit to be alive and present during client interventions. I believe that client interventions would benefit from the qualities of the MI spirit of collaboration, evocation, and autonomy to draw from clients their goals, values, and aspirations so that the client (not the practitioner) can determine why their change is required (Rosengren, 2009). The counselling style of MI is not a fit for everyone's personality. There will be staff who do not want to participate. There will be staff who do not want to participate in incorporating MI into their daily practise. In order to address the training of MI within work environments, there would need to be a top-down investment as a mandatory directive with in-house supports to train and mentor staff long term.



On August 13, 2018, I was offered this contract position as the intake/crisis worker on a fulltime basis with HSN, Manitoulin site, and I accepted. This practicum has given me the time needed to deepen my MI skill set, a renewed commitment to a reflective social work practice emphasizing professional development, and an innate desire to bring the needs of clients forward for effective change towards a more client-centred supportive mental health and addiction social system on Manitoulin Island.

### **Implications for Social Work Practise**

As MI is evidence based and has demonstrated effectiveness, it is the wide spread implementation that remains the problem. Emmons and Rollnick (2001) suggested that MI, in a healthcare or community health setting, needs to be implemented with these set guidelines: researchers need to know the population served as to create an intervention framework suitable to the setting and clients; input from the clients regarding design is critical; practitioners need to construct evaluation methods, provide ongoing supervision and follow up of MI skills; and more studies need to include comprehensive process evaluation. “For some behaviours, it is possible that MI has the strongest effect on motivation, and thus could become a cornerstone of stepped-care approaches in which motivation is first addressed, followed by skills-based interventions for those who are ready to change” (Emmons & Rollnick, 2001, p. 73).

### **Conclusion**

This practicum experience has awakened me to the importance of a reflective social work practice and the value of MI. I will carry this learning forward as I continue to work as a social worker within the field of mental health and addictions on Manitoulin Island. I want to thank HSN for this practicum opportunity that has led to my current fulltime position as intake/crisis worker. This experience has stirred in me a desire to be a more effective worker in this new employment role and to advocate the best I can for the needs of the future clients I will serve.

I am truly a changed person due to the exceptional guidance of Dr. Leigh MacEwan and Dr. Tanya Shute. I want to thank all the clients who shared their stories with me during this practicum. It is through their personal experiences that have fuelled my passion for social justice.

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## Appendices

### Appendix A: Health Sciences North Job Posting



Health Sciences North  
Horizon Santé-Nord

#### JOB POSTING

##### OPEN AFFILIATION

Date Posted: October 4, 2017

Posting #: 17-0826 Position: To Be Determined (Registered Nurse/Social Worker/Psychological Asso) Status: Temporary Full-Time (December 2017 to December 2018)

Program: Mental Health and Addictions Department: Crisis - Manitoulin Site: Manitoulin

**Purpose:** Provide assessment and management to clients with mental health and addiction concerns referred to the Crisis Program within the philosophy, objectives and policies of the Mental Health program. The clinician will also provide screening function for both Manitoulin and Espanola site.

**Education and Training:** Minimum of a BScN, BSW, or Master's Degree in Psychology or Clinical Psychology from an accredited University. Current Certificate of Registration in good standing with a regulated college. Applicants qualified to register with the college of psychotherapists may be considered. Current certification in Non-Violent Crisis Intervention (NVC) Certification/training in Crisis intervention skills. Proven knowledge of the Diagnostic Statistical Manual. Ministry of Labour "Worker Health and Safety Awareness in 4 Steps" training certificate is required.

**Experience:** Minimum of 2 years full-time equivalent experience working on an adult inpatient psychiatric unit or Crisis Intervention Program. Minimum of 2 years full-time equivalent experience (within the last 5 years) working on an acute medical floor or in emergency medicine. Minimum of 2 years full-time equivalent experience (within the last 5 years) in community mental health or addictions setting. Proven ability and experience providing mental health and addiction assessments with recommendations and in facilitating the development of treatment goals with clients.

**Knowledge/Skills Ability:** Strong interpersonal and organizational skills. Advanced oral and written communication skills. Evidence of practice based upon recovery principles. Extensive knowledge of community resources. Valid driver's license and access to a vehicle. Physical ability to travel between sites. Personal Suitability: Proven knowledge of the Mental Health Act and other relevant legislation. Demonstrated training/educational experience in crisis intervention, risk assessment. Demonstrated knowledge of Manitoulin Island community resources. Computer skills including Microsoft Office software, Meditech Client Service OE, and GRASP software. Criminal record check satisfactory to the Hospital. Selection Process: Candidates will be selected for this position on the basis of their skill, ability, experience and qualifications as identified in the resume and completed Application Form submitted. The Hospital reserves the right to conduct a formal interview where required. Shift: days French Language Service Designation: Bilingualism is an Asset Salary: TBDN.B. Applications for this position must be submitted to the Human Resources Department before 1600 hours on October 11, 2017.

Appendix B: Certificate of Completion – Understanding Stigma

# *Certificate of Completion*

*Presented to*

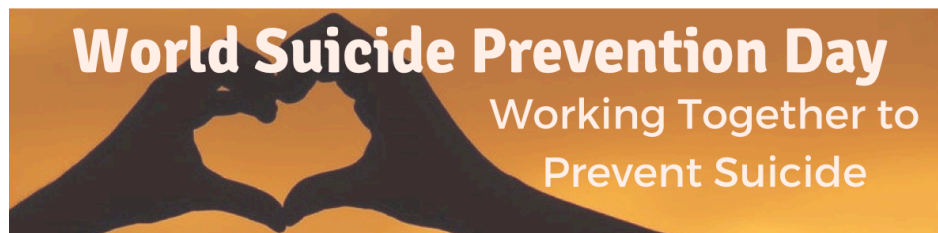
Kate Corbiere

*For completion of the following course:*

## Understanding Stigma



## Appendix C: World Suicide Prevention Day Poster

**Want to get involved? Here are a few ideas!****Light a candle**

Light a candle and place it near a window at 8pm on September 10th. Throughout the world, candles will shine as a beacon of hope. Light a candle to show your support for suicide prevention, to remember someone who has died by suicide, and to honour those whose lives have been impacted by suicide.

**Plan or attend an event in your community**

Planning an event? Share the information at [suicideprevention.ca/wspd](http://suicideprevention.ca/wspd) so that others in the community can learn more. Want to attend an event? Search for an event near you using the search tool at the website above. Participate in events that spread messages of hope--consider planting a tree in your community in honour of WSPD.

**Wear a ribbon**

For the third year, join with others throughout the world in wearing an orange and yellow ribbon as a sign of support for suicide prevention. The colours symbolize the flame of a candle – hope and light in the darkness. You can order ribbons by contacting CASP.

**Connect on social media**

Download one of the social media posters, write in what you will do on WSPD to help prevent suicide, and then take a picture and share it on social media. Be sure to use #WSPD18 when you post your picture! Change your profile picture to a yellow and orange ribbon, a candle, or one of the other social media images provided in the toolkit. Encourage others to get involved! Share resources online and encourage others to share.

**Reach out to someone in need**

When someone is struggling, the first step is taking a moment to check in with them and listen supportively and compassionately to what they have to say. You can start with, "I know you've been going through a lot lately. I want you to know I'm concerned about you." Remember that you don't have to have all of the answers, but be prepared to help them find resources and information if needed. Visit [suicideprevention.ca/need-help/](http://suicideprevention.ca/need-help/) to find resources in your community.

**Download and share the toolkit**

The toolkit contains a sample press release, letter to the editor, postcard, poster, and more! Visit [suicideprevention.ca/wspd](http://suicideprevention.ca/wspd) to find more resources, information, and ideas for getting involved!



September 10, 2018  
[suicideprevention.ca/wspd](http://suicideprevention.ca/wspd)



## Appendix D: Curriculum Vitae – Allan Chislett

**Curriculum Vitae**

**Allan J. Chislett, B.S.W., M.S.W., R.S.W.**  
**37 Rainbow Trail**  
**R.R. #1, Site 1, Comp 43**  
**Mindemoya Ontario, P0P-1S0**  
**Home 705-698-6083/ Work 705-377-4196**  
**Email: allanchislett91059@gmail.com**

**EDUCATION**

- 2003, Masters Degree Social Work
- 1999, Honours Bachelor of Social Work, Laurentian University
- 1999, Core Knowledge and Skills for Withdrawal Management
- 2003-2008, Advanced Critical Incident Stress Management
- 2003 treatment of Concurrent Disorders, Center for Addiction & Mental Health
- 2005, Externships with the eating disorders program at the Children's Hospital of Eastern Ontario, Ottawa
- 2005, Attachment Disorder in the treatment of PTSD, Hincks Dellcrest Institute
- 2005, Cognitive Behavioural Therapy, Beck Institute, Sault Ste. Marie
- 2006, Family Based Therapy for Anorexia Nervosa, trained by Dr. James Lock, Stanford University Department of Psychiatry
- 2006, Dialectical Behaviour Therapy with the Eating Disorders Network of Ontario, Toronto
- 2008, Multi-Family Therapy, In partnership with Hospital for Sick Children, Trained by Ivan Isler and Penny Fairburn, Maudsley Hospital London England

**EMPLOYMENT HISTORY**

- **Therapist in private practice**, Dan Keaney & Associates Counselling Service Inc. February 2011 to March 31, 2017
- **Family Worker**, Transitional Care Program, Sudbury Regional Hospital, July 2010 – February 2011
- **Family Therapist**, Eating Disorders Program, Community Mental Health, Sudbury Regional Hospital, December 2004 – July 2010
- **Adult Therapist**, Sudbury Regional Hospital Mood and Anxiety Program, Sudbury Regional Hospital; Currently
- **Critical Incident Debriefing** Mental Health Representative with Genevra house 2009 – Ongoing
- **Part-time Faculty** at School of Social Work, Laurentian University 2007- ongoing
- **Coordinator**, Marriage Preparation Program, Family Enrichment Centre, March 2004 – Feb. 2010
- **Placement Supervisor**, supervising 4th year Social Work students 2005
- **Faculty Consultant** School of Social Work, Laurentian University Spring/Summer 2005

- **Clinician**, Regional Concurrent Disorder Program, Northeast Mental Health Centre, Nov. 2001 – December 2004
- **Addictions Counsellor**, PineGate Addiction Service, Northeast Mental Health Centre, November 2000 to Nov. 2001
- **Crisis Intervention Worker**, Sudbury Regional Hospital (HRSRH), Nov. 1999 to Nov. 2000
- **Children's Mental Health Worker**, Espanola Mental Health Clinic, Northeast Mental Health Centre, July 1999 to December 1999
- **Men's Withdrawal Management Services**, Northeast Mental Health Centre March 1999 to July 1999
- **Life Skills Trainer**, Sudbury Community Service Centre (MCSS), April 1999 to July 1999
- **Addictions Counsellor (Supervised)**, 4th year internship at Salvation Army Substance Abuse Treatment Centre, Sept 1998 to December 1998
- **Teaching assistant (Supervised)** 3rd year internship at Cambrian College in the Adult upgrading program, winter 1996, spring 1997.

### COMPLETED RESEARCH

- A Qualitative Research Study of Men's Experience with Depression Using Collage as a Mediator, 2003. Thesis submitted to the Department of Graduate Studies in partial fulfillment of the requirements for the degree of Master of Social Work. Department of Graduate Studies Laurentian University, Sudbury Ontario, September 2003
- Needs Assessment and development of Parent Support Group for Caregivers whose child have an eating disorder, 2006
- Needs Assessment for the development of a Regional Service Delivery Model for Consumer/Survivors with a Concurrent Disorder and their families, June 2004. Needs assessment conducted by the Northeast Mental Health Centre and submitted to the Ministry of Health and Long-term Care, Spring of 2004

### ASSOCIATIONS

- Ontario College of Social Workers and Social Service Workers, Registration # 125001
- Ontario Association of Social Workers
- Society for Clinical and Experimental Hypnosis (Ontario division)

### Skills

#### Self-employed: Mental Health Therapist in Private Practice

- Provide therapy for depression, anxiety, grief, Critical Incident stress, trauma and couples counselling
- Family Therapy/Support
- Life Skills Management

- Provide skills training for adult clients diagnosed with ADHD
- Provide workshops on Bullying in the workplace

### **Associate Therapist in private practice**

- Provide therapy for depression, anxiety, grief, Critical Incident stress, trauma and couples counselling
- Family Therapy/Support
- Life Skills Management
- Provide skills training for adult clients diagnosed with ADHD
- Provide workshops on Bullying in the workplace

### **Transitional Care Family worker, Long-term Disability unit**

- Assess family problems associate with supporting elderly person in hospital and transition to long-term care
- Family counselling
- Attend rounds provide feedback on follow through on doctor orders

### **Family Therapist, Eating Disorders Program**

- Assessment of eating disorder
- Family therapy and counselling
- Crisis management
- Teaching full age spectrum and families
- Education and training to community agencies
- Clinical services to children, youth, teens and adults
- Assess for co-morbidity with eating disorder clients and their families
- Program design and delivery
- Liaising with partner agencies
- Develop PowerPoint presentations providing education other service providers.

### **Critical Incident Management**

- Group leader
- Debriefing groups with debriefing team using model by Everly and Mitchell
- Educated management of post-trauma distress and maintaining mental health
- Crisis management
- Referral to appropriate services

### **Coordinator, Marriage Preparation Program**

- Team Leader
- Supervise staff
- Train/mentor new staff
- Coordinate and facilitate team meetings
- Data collection
- Design, teach and present workshops on sexuality, family of origin, communication and conflict resolution

### **Part-Time Faculty, Laurentian University, School of Social Work**



- Taught Basic Counselling Skills to 2<sup>nd</sup> year Students
- Taught Social Work Groups, theory and practice 3<sup>rd</sup> year Students

#### **Clinician: Regional Concurrent Disorder Program**

- Needs Assessment
  - Case management-Psychosocial Assessment
  - Functioned in Multi-Discipline team meetings
  - Discharge planning
  - Crisis management
  - Motivational Counselling
- 
- Liaise with psychiatrists and Community Services
  - Presenting to community partners

#### **Addiction Counsellor: PineGate Addiction Service**

- Interdisciplinary Team member
- Intake, assessment, and referral
- Case management
- Managing case notes and charts
- Individual and Couples therapy
- Group facilitator (Tx & after care)

#### **Crisis Intervention Worker**

- Assessing severity of mental illness in a hospital emergency room setting
- Psycho-social assessment
- Referring clients to emergency department and community services
- Communicating with emergency doctors and psychiatry
- Advocate for admission, psychiatric referral and community support
- Crisis counselling with adults and couples using brief solution focused strategies

#### **Mental Health Worker Espanola Mental Health Clinic**

- Counselling children and youth to 17 years of age
- Family counselling
- Interview, assess and goal set based on client needs
- Manage case load of 50 clients
- Part of Interdisciplinary team
- Network with community agencies and schools

#### **Men's Withdrawal Management Service**

- Observe psycho-emotional and physical condition during detoxification
- Log client status reports hourly
- Provide crisis intervention
- Communicate with emergency services
- Access community supports for discharge planning
- Intake and assessment

- Use of Stages of Change Model by Prochaska and DiClemente

### **Life Skills Trainer**

- Educate one-on-one with adult males to develop positive social and behavioural strategies while living independently
- Teach individual life skills in the home and the community
- Emotional and motivational support

### **Clinical Hypnosis**

- Trained by and Member of Ontario Society for Clinical and Experimental Hypnosis (Ontario Division)
- Trained in Dr. Francine Shapiro's model of Eye Movement Desensitization Reprocessing Therapy. Trainers Kathy Karn M. Ed, Psychotherapist and Dr. Brynha Snyder Clinical Psychologist

### **Areas of Knowledge and Interest**




- Neuroscience
- Attachment theory
- ADHD skills training

UMAT- ADULT ASSESSMENT					
<b>Date:</b> _____ <b>SH#:</b> _____ <b>Name:</b> _____ <b>D.O.B.:</b> _____ <b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: <b>Arrival (self, Police, family EMS):</b> _____		<b>Time:</b> _____ <b>Client on Form</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Is there an AOB alert</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Last Crisis contact:</b> _____ <b>Last ED mental health presentation:</b> _____ <b>Physical Description:</b> _____			
<b>PRESENTATION</b>					
<b>REASON FOR PRESENTATION:</b> _____ _____					
<b>RTA:</b> _____					
<b>RISK</b>					
<b>Suicide Risk Assessment</b> <b>Suicidal Thoughts:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Suicidal Plan:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes method/timeline: _____ <b>Available Means:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Have you made any preparations</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Previous Attempts:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Family Hx Suicide:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Recent Loss(es):</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____  <b>Willing / Able to Contract for Safety:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____			<b>Violence Risk Assessment</b> <b>Homicidal Thoughts:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Plan / intensity of Ideation:</b> _____ <b>Available means:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Previous Hx:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____ <b>Police or intended victim contacted:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____  <b>History of aggression:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes details: _____		
<b>Protective Factors</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> None <input type="checkbox"/> Unknown details: _____					
<b>Safety Plan:</b> _____ _____					
<b>RTA:</b> _____					
<b>RECENT STRESSORS:</b> _____ _____					

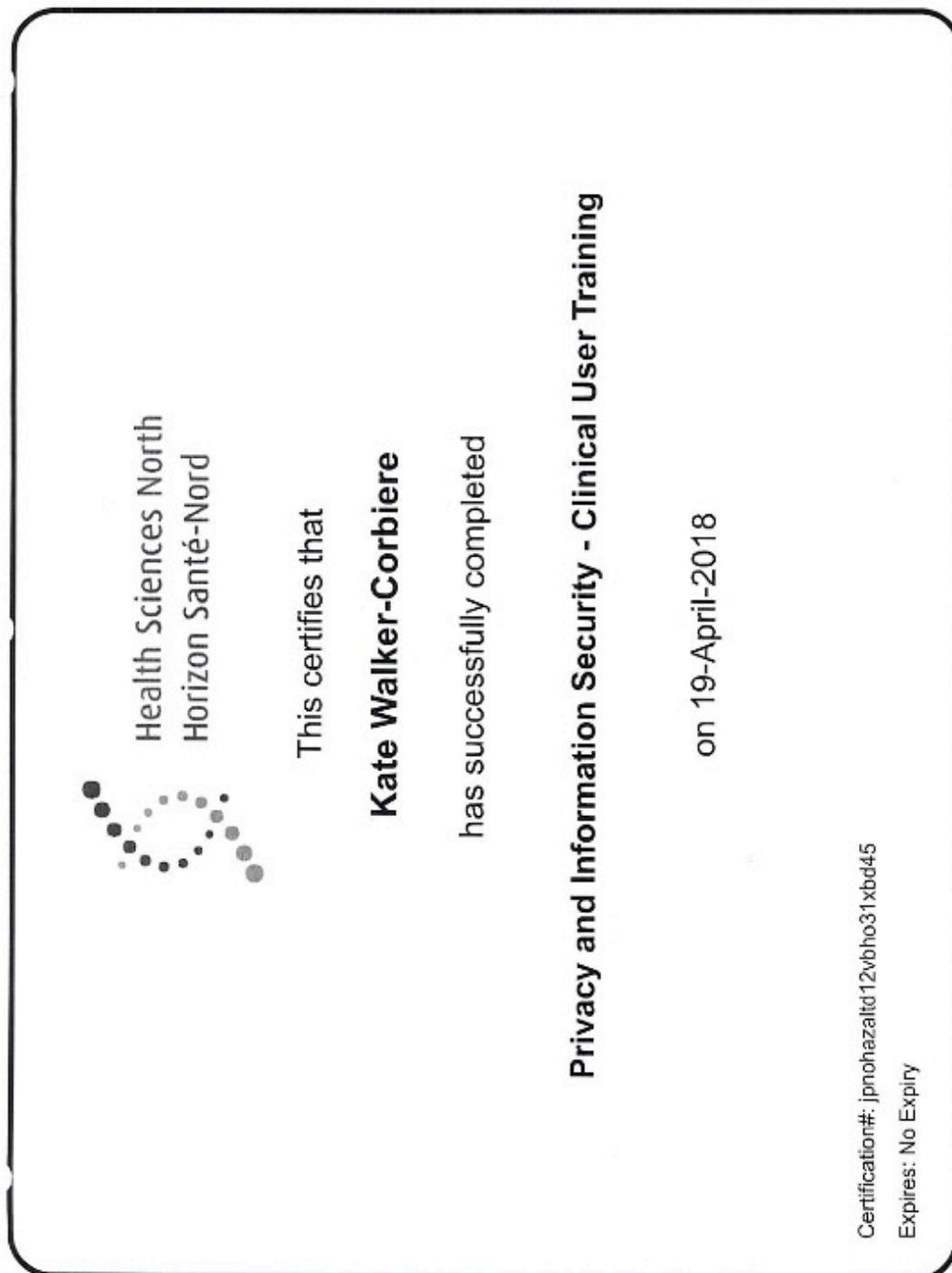
## Appendix F: Regional Concurrent Disorders Program Certificate of Participation



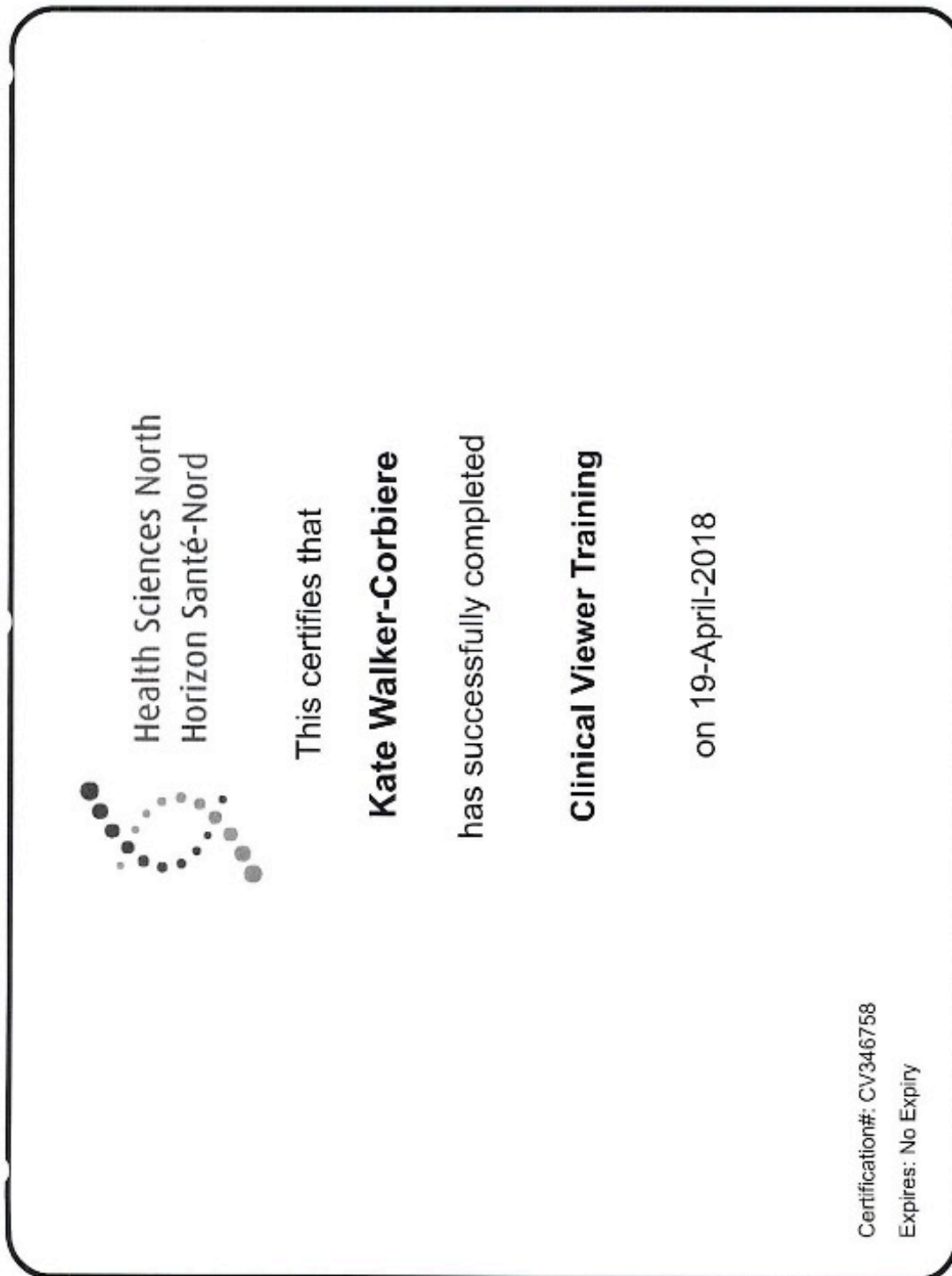
## Appendix G: Certificate of Attendance Choices and Changes

 <p>Institute for Healthcare Communication</p>	<p><b>CERTIFICATE OF ATTENDANCE</b></p>
<p>The Institute for Healthcare Communication certifies that</p>	
<p><b><i>Kate Walker-Corbriere, HBSW, RSW</i></b></p>	
<p>has completed</p>	
<p><b>Choices and Changes: Motivating Healthy Behaviours</b></p>	
<p>Presented on</p>	
<p><b>March 9, 2018</b></p>	
<p>at</p>	
<p><b>Sudbury, Ontario</b></p>	
<p>for</p>	
<p><b>4.25 hours</b></p>	
<p>               Kathleen A. Bonvicini, EdD, MPH              Chief Executive Officer           </p>	
 <p>THE COLLEGE OF FAMILY PHYSICIANS OF CANADA</p>	<p><i>This Group Learning program has been certified by the College of Family Physicians of Canada for up to 6.0 Mainpro-1 credits.</i></p>
<p>Institute for Healthcare Communication, Inc.   171 Orange Street   2R   New Haven, CT 06510-3153   (800) 800-5907   info@healthcarecomm.org   www.healthcarecomm.org</p>	

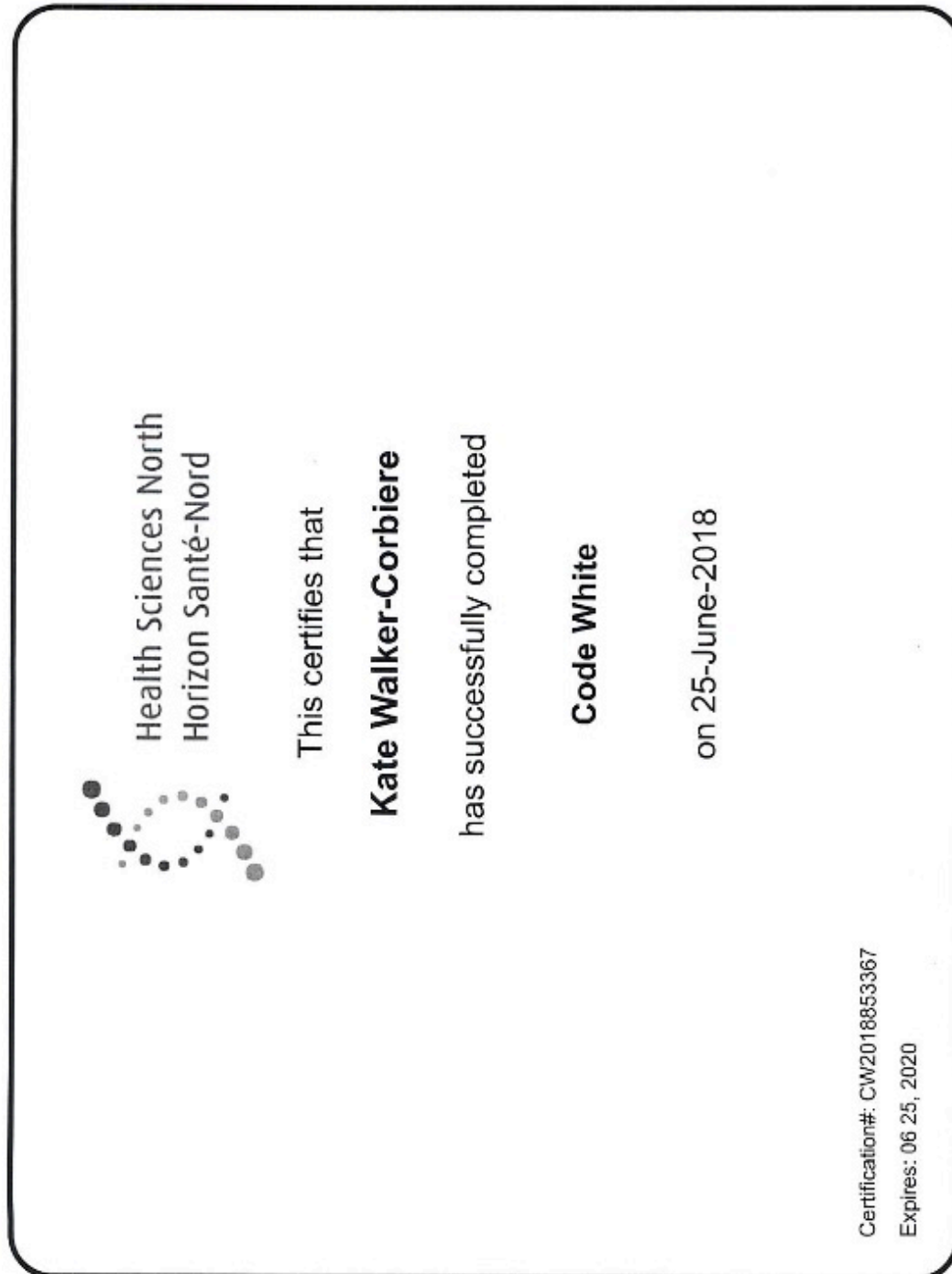
## Appendix H: Privacy and Information Security – Clinical User Training



Appendix I: Clinical Viewer Training

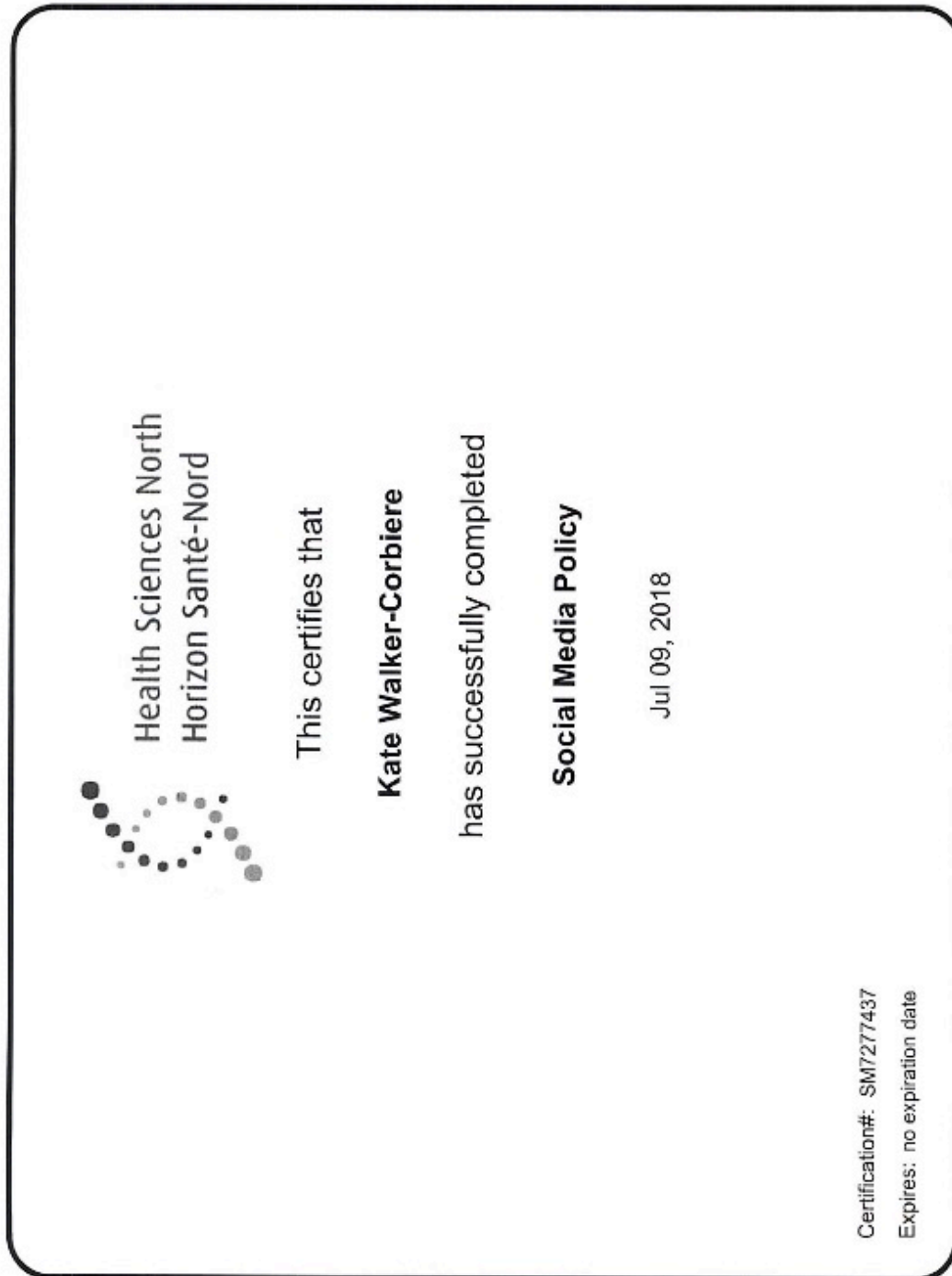


Appendix J: Code White

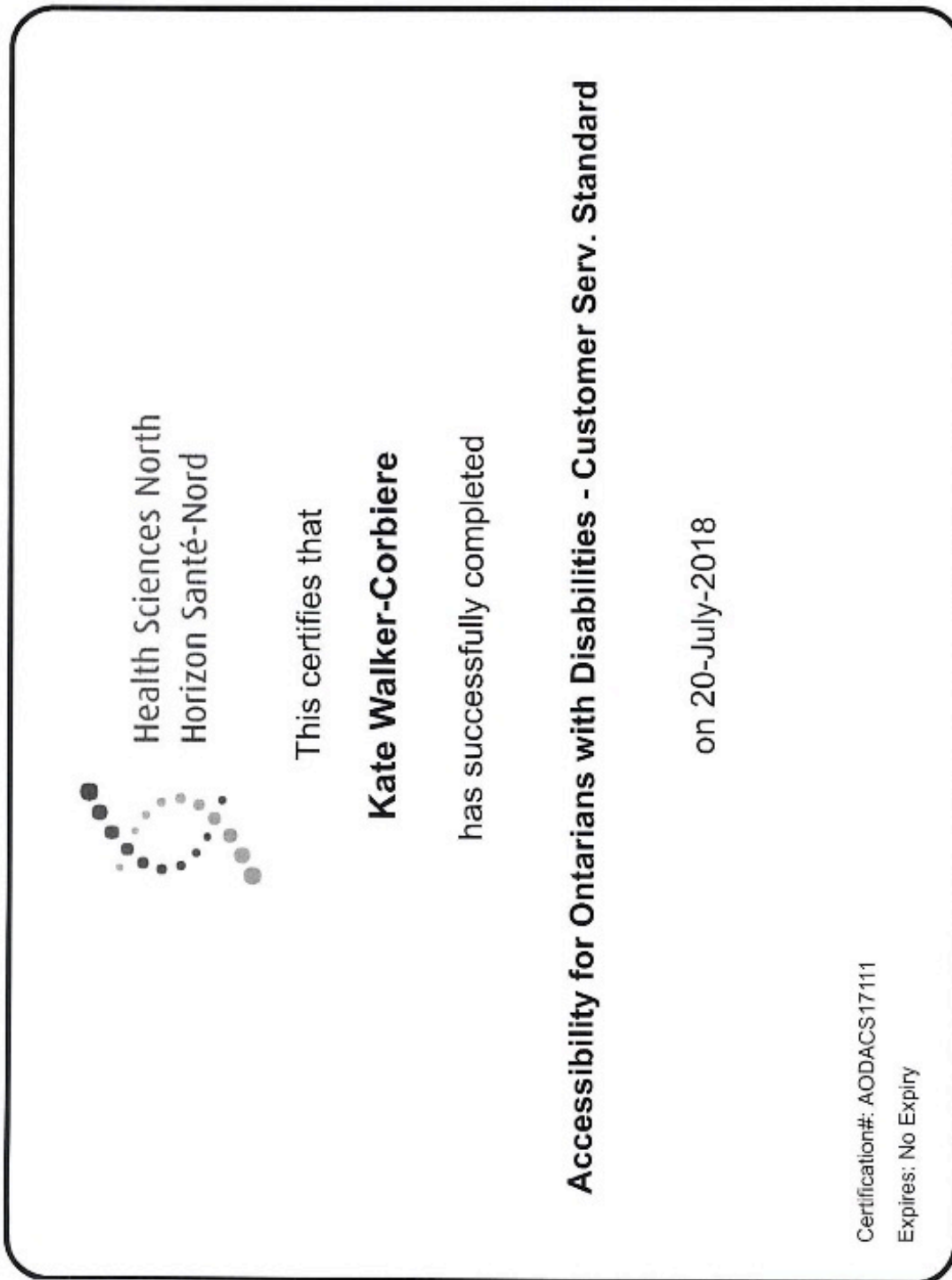




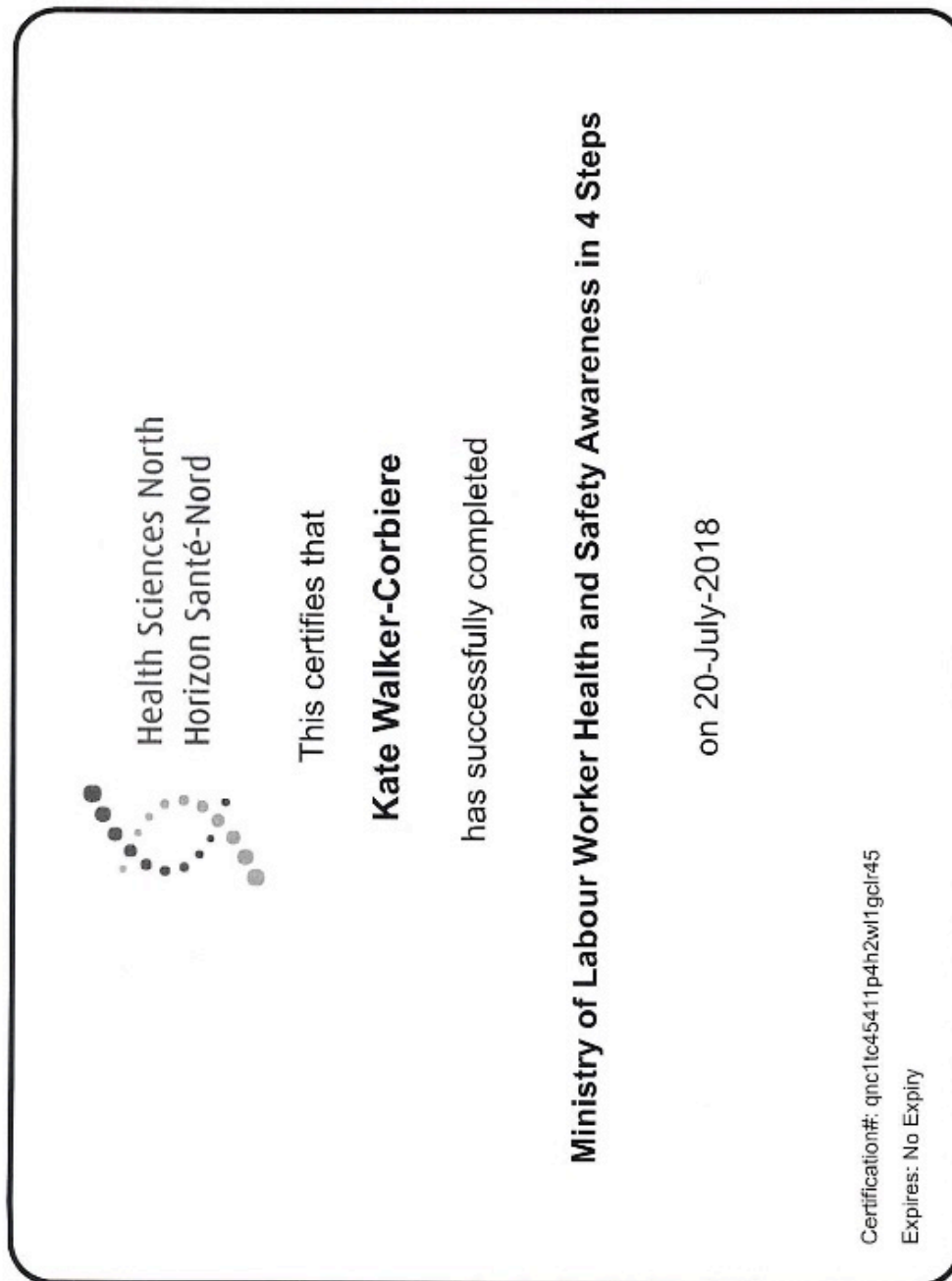
Appendix K: Social Media Policy



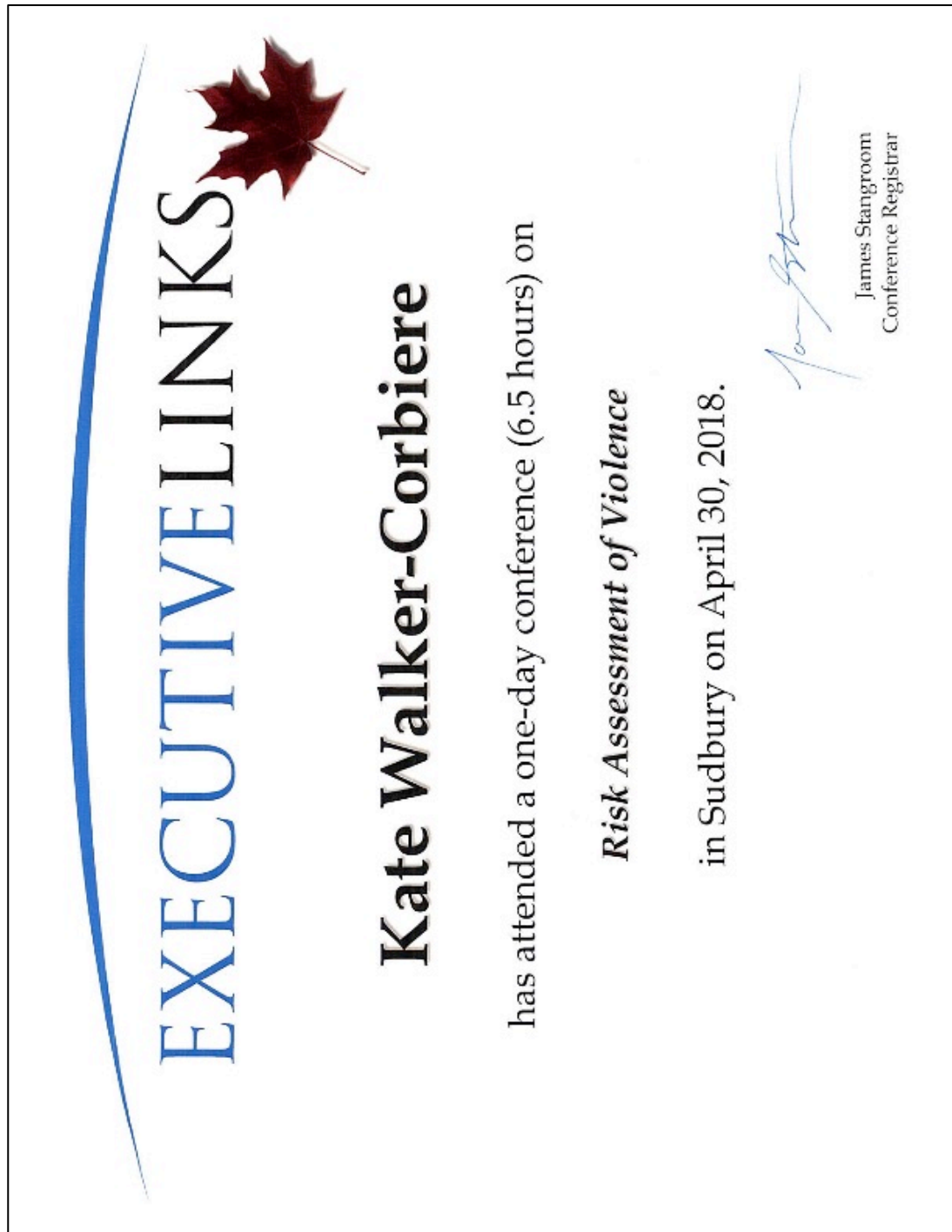
Appendix L: Accessibility for Ontarians with Disabilities



Appendix M: Ministry of Labour Worker Health and Safety Awareness in 4 Steps



## Appendix N: Risk Assessment for Violence



## Appendix O: Sample of Journal Form

Sample of Journal Form:

SPIRIT OF MI: Collaboration, Evocation, Autonomy

PRINCIPLES: Empathy, Self-efficacy, Roll with resistance

Date:

Type of Intervention:

Facilitator:

Observer:

OARS open questions affirmations reflections summary	What did I hear?	How did I respond?
Preparatory Change Talk  Desire Ability Reason Need		
Implementing Change Talk Commitment Activation Taking Steps		

Conclusions: What worked.	Areas of Improvement: What didn't work.